U.S. DEPARTMENT
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Substance Abuse and
Mental Health Services
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Center for Substance Abuse Treatment

Screening and Assessment of Alcohol- and Other Drug-Abusing Adolescents

Treatment Improvement Protocol (TIP) Series

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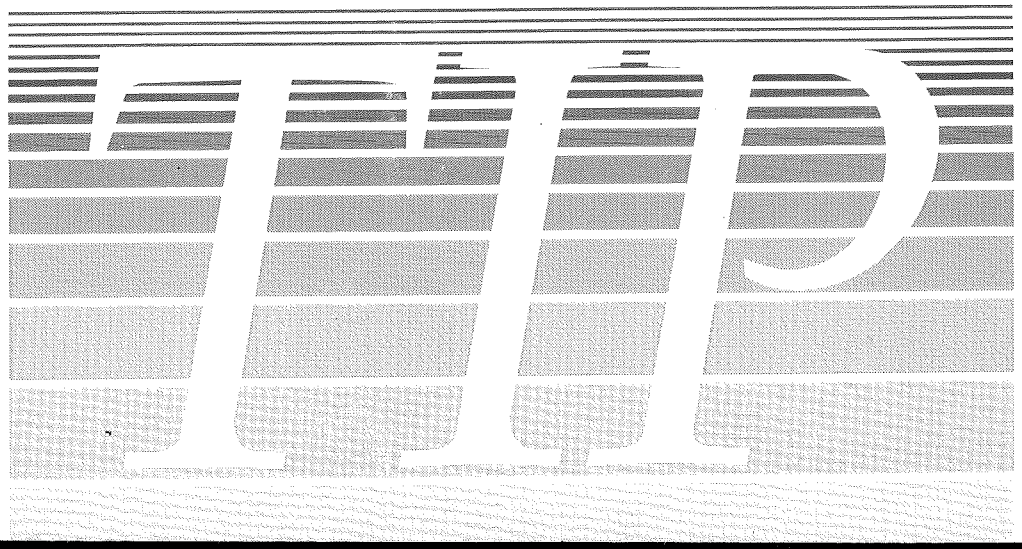

Screening and Assessment of Alcohol- and Other Drug-Abusing Adolescents

Treatment Improvement Protocol (TIP) Series

3

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This publication was written under contract number ADM 270-91-0007 from CSAT. Al Getz, M.S.W.; Anna Marsh, Ph.D.; and Sandra Clunies, M.S., served as the CSAT government project officers. Elayne Clift, M.A.; Carolyn Davis; Janice Lynch; and Claudia Norris, M.A., served as contractor writers.

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What Is A TIP?

CSAT Treatment Improvement Protocols (TIPs) are prepared by the Quality Assurance and Evaluation Branch to facilitate the transfer of state-of-the-art protocols and guidelines for the treatment of alcohol and other drug (AOD) abuse from acknowledged clinical, research, and administrative experts to the Nation's AOD abuse treatment resources.

The dissemination of a TIP is the last step in a process that begins with the recommendation of an AOD abuse problem area for consideration by a panel of experts. These include clinicians, researchers, and program managers, as well as professionals in such related fields as social services or criminal justice.

Once a topic has been selected, CSAT creates a Federal resource panel, with members from pertinent Federal agencies and national organizations, to review the state of the art in treatment and program management in the area selected. Recommendations from this Federal panel are then transmitted to the members of a second group, which consists of non-Federal experts who are intimately familiar with the topic. This group, known as a non-Federal consensus panel, meets for about three days, makes recommendations, defines protocols, and arrives at agreement on protocols. Its members represent AOD abuse treatment programs, hospitals, community health centers, counseling programs, criminal justice and child welfare agencies, and private practitioners. A chair for the panel is charged with responsibility for ensuring that the resulting protocol reflects true group consensus.

The next step is a review of the proposed guidelines and protocol by a third group whose members serve as expert field reviewers. Once their recommendations and responses have been reviewed, the chair approves the document for publication. The result is a TIP reflecting the actual state of the art of AOD abuse treatment in public and private programs recognized for their provision of high quality and innovative AOD abuse treatment.

This TIP, on the screening and assessment of AOD-abusing adolescents, is the third published by CSAT since a treatment improvement initiative began. It represents another step by CSAT toward its goal of bringing national leadership to bear in the effort to improve AOD abuse treatment.

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Chapter 1—Introduction

History: The Development of This Treatment Improvement Protocol

Alcohol and other drug (AOD) abuse and AOD abuse-related problems among adolescents are among society's most important and pervasive medical and social concerns. Adolescent AOD abuse is a disorder that robs children of their potential as adults, thus making it one of the most expensive health care problems facing our society.

There has been far less research and clinical attention paid to adolescent AOD abuse than to the adult form of this disorder. One major reason for the lack of progress in the treatment and research of adolescent AOD abuse is the lack of reliable, valid, and clinically useful instruments[1] and procedures to:

- Identify potential AOD abusers,
- Assess the full spectrum of treatment problems,
- Plan appropriate interventions,
- Involve the youth's family, as defined below, in all aspects of intervention,
- Evaluate the effectiveness of the interventions that are actually used, and
- Assess AOD problems in the context of the youth's overall development.

It is also important to train all levels of personnel in the skills needed to identify, evaluate, diagnose, and plan treatment for adolescents with AOD abuse and related problems.

In recognition of the importance of developing reliable, valid, and clinically useful instruments as well as procedures for wide general use in screening for adolescent AOD abuse, the Center for Substance Abuse Treatment (CSAT) in 1992 convened a panel of experienced researchers and clinicians who work with troubled adolescents and their families. CSAT also convened another panel that examined AOD abuse treatment for adolescents and outlined state-of-the-art treatment guidelines. This Treatment Improvement Protocol (TIP) on screening and assessment should be viewed as a companion volume to the TIP on treatment, and many readers will want to study both.

The panel on adolescent AOD abuse screening and assessment was charged with attaining two goals. The first was to discuss the problems of adolescent AOD abuse from the viewpoints of the panel members, who came from a spectrum of different backgrounds and specialty areas. The emphasis was on practical clinical procedures that could help to improve care, rather than on rigorous scientific theories that could guide new research. A second goal for the panel was to review, from a practical perspective, available instruments, procedures, and measures for assessing adolescent AOD abuse in various settings, including rehabilitation, that could be used easily by clinicians and other workers in the field.

Three Guiding Principles For Adolescent AOD Screening and Assessment

- Young people deserve effective, appropriate care.
- Young people have a right to privacy and to confidential handling of any and all information they provide.
- Program staff must consider cultural, racial, and gender concerns in all aspects of the screening and assessment process.

Purposes of This TIP

This TIP summarizes the results of the consensus panel's deliberations. The volume concentrates on the strategies, procedures, and instruments that are appropriate for the initial detection of AOD-using or -abusing adolescents, the comprehensive assessment of their problems, and subsequent treatment planning. The TIP does not prescribe any screening or assessment tool.

The purposes of the TIP are several:

1. To provide personnel involved in screening and assessing AOD abuse in youth (e.g., guidance

counselors, substance abuse counselors, or nurses) with general guidelines for evaluating, developing, and administering screenings and assessment instruments and processes.

2. To inform a wide range of people whose work brings them in contact with adolescents in problem situations (for example, teachers, guidance counselors, school nurses, police probation officers, coaches, and family service workers) about the processes, methods, and tools available to screen for potential AOD problems in adolescents.
3. To discuss strategies and accepted techniques that can be used by primary AOD abuse treatment personnel to detect related problems in the adolescent's life, including problems with family, peers, and psychiatric issues, and to see that these problems are dealt with during the primary AOD abuse intervention.
4. To outline an assessment system designed to screen teenagers with potential AOD problems at various points of identification.

Guiding Principles

Three basic principles guided the panel's efforts:

1. *Adolescents deserve effective, appropriate care.*

Thus, parents, teachers, physicians, police, and a variety of other adults who come into regular contact with adolescents have the obligation to use appropriate and effective means to identify potential AOD abuse problems among adolescents. Adults also have the obligation to follow screening and assessment procedures with sensitive, direct treatment and interventions that are indicated by the results of the assessment procedures. Failure to follow through is unprofessional and unethical.

It is important that preliminary screening and comprehensive assessment be seen not as ends in themselves, but rather as part of a process of obtaining increasing depth of insight into the nature, correlates, and consequences of the youngsters' AOD problems. Therefore, it is important that this process be embedded in a continuum of activities that includes responding to the identified needs of given youths.

Follow Through

- The detection of potential AOD abuse in a youth requires sensitive, direct follow-through.
- Failure to follow suggestive results with additional assessment is unprofessional and unethical.

2. *Adolescents have a right to privacy and to confidential handling of any information they provide.*

Screening and assessment are not neutral or passive procedures. Used intelligently, they can provide vital information to appropriate professionals, thus contributing to effective care. Used in a careless or unprofessional manner, there is the potential for significant harm to the very individuals who need help.

In the discussions that follow, these guiding principles concerning adolescents' rights with respect to privacy and confidentiality are emphasized repeatedly to make clear the need for professional and sensitive handling of information on adolescents at each step of the assessment process.

3. *Program staff must consider cultural, racial, and gender concerns in all aspects of the screening and assessment process.*

It is vital for program staff to have a keen understanding of the impact that culture, race, and gender of both the young person and the staff members can have on screening and assessment. Multiethnic, multicultural programs are essential in today's society. People involved in the assessment process must be aware of how their own culture and ethnic background and their life experiences affect the assessment process.

Terms Used in This TIP

The adolescent. This volume uses the broadest possible definition of an adolescent—an individual 11 to 21 years of age. This definition captures the great majority of the physical changes associated with adolescence and the maturing of a child into an adult. The emotional and behavioral transitional stages that have traditionally been associated with the teenage years (e.g., dating to marriage, sexual experimentation to childbearing and parenting, dependent to independent living, and school to work) have changed. In today's society, the adolescent's actual age or physical stage of development does not always correspond with the emotional or behavioral situations of her or his life. It is no longer unusual to see sexually active 11- to 13-year-olds, 15- to 17-year-olds who live independently from their parents, or 14- to 18-year-olds who are responsible for a family.

The diversity of physical, emotional, and behavioral stages among adolescents makes AOD abuse screening, assessment, and treatment planning for this group of individuals especially challenging. The discussions in this TIP assume that adolescents of different ages may have very similar types of problems and treatment needs; on the other hand, adolescents of the

same age may be at very different stages of development.

It is obvious that alcohol use in a 13-year-old has much more significance and demands a more actively aggressive intervention than the same amount or frequency of alcohol use in a 19-year-old. Similarly, the types and quality of relationships that an adolescent experiences with family, school, work, and peers will vary significantly.

Throughout this volume, several different terms are used to refer to the adolescent client: adolescent, youth, teenager, child, and young person.

The family. The family is a key element in all aspects of adolescent AOD abuse screening, assessment, and treatment. However, before assessors involve families in the assessment process, they must reconsider the traditional definition of family (that is, a mother, father, and children all living together). Traditional definitions of family are no longer applicable for many members of society. For example, a family may consist of a grandmother and her grandchildren, a single mother living with her boyfriend who may be helping to raise the children, or foster parents raising several children. An expanded definition of family may assist the assessor in identifying individuals who can support the screening and assessment process, and assist the young person as well.

Some adolescents establish family-like ties with peers through gangs. For some adolescents, their gang is their family. Gangs can supersede the power and authority of the traditional family. Assessors must recognize that gang affiliation may greatly influence the AOD-involved adolescent.

As assessors seek to define the family, they should bear certain principles in mind:

- The definition of "family" must be as inclusive as possible, recognizing the diversity of family life in America.
- The law and society may define family in ways that differ from the actual experiences of AOD-abusing youth.
- Adolescents may define family in nontraditional ways. Treatment providers should allow adolescents to identify and acknowledge the people they would describe as "family," even though they may not live with the adolescent.
- Cultural and ethnic differences in family structures should be respected.
- Socioeconomic, cultural, and ethnic factors are not always equivalent, and should not be confused.

Even when these principles are used to redefine the family, the family's function continues to be much as it has always been: to meet family members' physical, emotional, spiritual, and cultural needs. At their most basic, physical needs include the need to be fed, sheltered, and protected. To meet emotional needs, the family nurtures, disciplines, guides, and supports its members. In meeting spiritual and cultural needs, families impart their values. Spirituality may be defined by the family's own traditions and rituals. All of these factors should be respected when dealing with adolescents and their families. People who serve as family in the adolescent's life because they provide for physical, emotional, and/or spiritual needs should be considered family for the purposes of screening and assessment.

Throughout this volume, there are frequent references to the youth's family, parents, and guardians. Although in some instances the legal definition of parent or guardian is intended, in many other instances the reader should keep in mind this broad definition of family. In addition, the terms "parent" and "guardian" are used interchangeably throughout the text.

When a child has had foster care placements, the role that foster parents play in a child's life must be taken into consideration, although these parents are not the legal guardians of the youth. (A youth in foster care is legally "a ward of the State," and thus the State is the legal guardian.)

Family Members

Family is anyone who meets the youth's physical, emotional, spiritual, and cultural needs.

- Current foster parent(s)
- Former foster parent(s)
- Other children placed in current or previous foster homes
- A relative or close friend of a foster parent
- An incarcerated natural parent
- A friend
- An adult, perhaps a teacher or social worker, who is close to the youth
- A grandparent, aunt, uncle, or other member of the traditional "extended" family
- Members of a neighborhood gang.

The importance of family involvement throughout the assessment process is discussed in this volume. Assessors should receive training in theories and concerns about "family systems." It should be kept in mind, however, that despite the importance of family involvement in assessing troubled youth, agencies are often frustrated by the lack of available resources needed to adequately include the family in the process. Thus, although family involvement in screening and assessment, as well as in treatment, is usually highly recommended, it is not always feasible.

AOD abuse. What is meant by AOD abuse? Despite a vast amount of literature discussing the difference in diagnosis between

"use" and "abuse," these terms are often used interchangeably in discussing adult alcohol and drug use. In addition, in the literature on adult AOD use, there has been a great deal of discussion of the terms "abuse" and "dependence." However, many workers use the terms interchangeably.

The terms "abuse" and "use" are often used interchangeably with respect to adolescents for two key reasons. First, all street drugs are illegal. Alcohol use by a person under the age of 21 is illegal in all States. Thus, on legal grounds alone, any use of these substances by adolescents should be considered abuse. In addition, given the rapid physiological changes that occur during adolescence, it is reasonable to consider AOD use as the "abuse" of a developing body and personality.

In this volume, AOD abuse in adolescents is defined as the use of AODs at a level that creates problems in one or more areas of functioning for the young person and requires intervention. The consensus panel members are committed to a focus on teens whose AOD use may require health care or social service resources to correct.

Adolescent AOD Abuse

AOD abuse in adolescents is the use of AODs at a level that creates problems in one or more areas of functioning for the young person and requires intervention.

Assessment. Assessment is a broad term including a range of evaluation procedures and techniques designed to measure key areas of adolescent functioning as well as the adolescent's environment. The term conveys the idea that assessment procedures are not single events, but instead involve the integration of client and treatment measurement techniques of different types, at different times, and for different purposes during the course of various interventions designed to have an impact on adolescents' AOD problems.

In this volume, four different types of assessment are mentioned. The first two types will be explained more fully in subsequent chapters.

1. The preliminary screening is conducted when an adolescent has noticeable (to responsible adults in a variety of roles) problems that *may* be AOD-related.
2. The comprehensive assessment is conducted when preliminary screening indicates that a youngster may have an AOD problem requiring detailed assessment. Its purpose is to help design an intervention.
3. The quality assurance assessment is taken as treatment or intervention services are being provided. (See chapter 5 regarding quality assurance in treatment of juveniles in the justice system.)
4. The outcome assessment is done after the intervention or treatment has been completed, to determine the nature and context of changes that have taken place. This type of assessment, while important, is not the subject of this TIP.

Intervention. While a major focus of the present volume is on treatment, the term *intervention* also has a much broader meaning. It includes any effort made to correct the problematic behaviors seen in AOD-abusing adolescents. Among the least intrusive but often effective interventions are conversations between an adolescent and a concerned parent, teacher, physician, or friend. More formalized interventions include school-based prevention efforts, drug education classes, or focus groups, for example.

Perhaps the most common interventions are treatment efforts that may take place in outpatient, partial hospital, or residential settings (including correctional facilities). "Partial hospitalization" is a term used to refer to the provision of daytime care with clients returning home overnight.

A special set of interventions occurs within the juvenile justice system (JJS) and includes arrests, probation, and detention. A primary purpose of these interventions is the correction of illegal and antisocial behaviors. However, it has been understood for a long time that AOD abuse is commonly associated with these problem behaviors.

What Is An Intervention?

An intervention, in reference to adolescent AOD abuse, is any effort to correct problem behaviors in AOD-abusing youth, including:

- Conversations with a youth and a concerned adult
- Outpatient treatment
- Partial hospitalization
- School-based prevention
- Residential treatment
- Drug education classes.

For this reason, AOD abuse treatment services are often a significant part of JJS interventions with troubled adolescents. Because of the special circumstances surrounding JJS interventions and the large number of adolescents identified and processed within that system, this volume has a special chapter devoted to the discussion of JJS-AOD abuse assessment procedures.

A Multifaceted Approach

AOD abuse among adolescents rarely occurs in isolation. Use of alcohol and street drugs is usually associated with problems in areas of school performance, peer and family adjustment, medical and/or

psychiatric health, and crime. This volume addresses the impact of screening and assessment measurement issues on these different aspects of a young person's life, for two reasons:

1. Many types of professionals who deal with adolescents are in a position to evaluate, or at least detect, the possibility of AOD use as a complicating factor in the youth's presenting problems. For example, police who find a runaway adolescent should be able to evaluate the potential contribution of AOD use to his or her situation. Similarly, a school nurse asked to evaluate a student who continues to fall asleep in class should be sensitive to the possibility that unobserved AOD use may be contributing to the observed behavior problem.
2. The treatment of AOD abuse in adolescents (as in adults) is likely to involve issues in several associated or affected areas, such as family relations (see below), nutrition, psychiatric problems, etc. Personnel working with AOD abuse should be sensitive and sophisticated enough to detect significant problems in other areas of the adolescent's life outside the immediate setting in which they come into contact with the youth. These additional considerations should be incorporated into the treatment and referral plans associated with the AOD abuse intervention.

A multifaceted approach provides for different types of evaluations, as appropriate, at different points in the screening, assessment, and treatment process. At each assessment point, the target population, the purpose for collecting the information, the set of qualifications needed by the person doing the assessment, and the uses of the information obtained are somewhat different.

Selection of Screening and Assessment Instruments

Selection of screening and assessment instruments for use in the juvenile justice system needs to be guided by several factors: (1) reliability and validity indicators, (2) the adolescent population(s) for which the instrument was normed and developed, (3) the type of settings in which the instrument was developed, and (4) the intended purpose of the instrument.

Important features of screening and assessment instruments include:

- High test-retest reliability: In other words, are there similar results when the test is given again to the same youth at a later point in time—for instance, later that day or week?
- Strong correlation with other instruments attempting to measure the same construct (that is, AOD abuse problem severity): Is there a strong relationship between the results obtained from this instrument and the results obtained from other instruments designed to look at the same kind of problem?
- Demonstrated ability to predict criterion measures (for example, school performance, performance in treatment, and substance abuse relapse): Has the test proven over time that it has helped to predict certain specific behaviors in young persons in the same or similar populations?
- Availability of normative data for age, race, gender, and different types of populations and settings (for example, school, detention center, and residential substance abuse treatment program): Has research been done to show the extent to which this test or instrument has been used successfully among different populations of young people and in different kinds of settings?
- The ability to measure cognitive and behavioral changes over time: Has the test been able to measure changes in a young person's behavior as well as changes in his or her thinking, reasoning, and remembering (Crowe and Schafer, 1990)?

AOD Assessment Process

Different types of assessments are appropriate at different times. At each point, the following factors may change:

- Target population (who should be assessed)
- Purpose for collecting the information
- Qualifications needed by the person(s) doing the assessing
- Use of information
- Skill level

Organization of This Volume

- **Chapter 2: Preliminary Screening of Adolescents.**

This chapter explores the key issues regarding preliminary screening of adolescents who may have an AOD problem, including the setting, the assessor, screening, necessary training, and use of community-wide coordination.

The appropriate evaluator is any person who is in a responsible position in a situation where an adolescent has been identified because of a problem. Examples include a teacher who notices chronic truancy or failure to complete assignments, a school nurse who is asked to evaluate a chronically sleeping student, a guidance counselor who is asked to assist in motivating a student, a parent who notices negative changes in the behavior of a son or daughter, or a police officer who arrests a teenager for a legal violation.

Key issues for AOD abuse screening include:

- Ease of use;
- Expertise and training required to administer the test;
- Amount of time required to administer it;
- The extent to which the instrument takes the family into consideration as part of the assessment process;
- Possibility of bias, particularly cultural bias;
- Cost per interview;
- Motivation level and language skills required of the youth;
- Ability of the interviewer to detect "good faking" or random responses;
- Age-appropriateness of instrument;
- Credibility of the test with the professional community and with people who have a stake in the adolescent's case.

Another consideration that is rapidly increasing in importance is the availability of computer software programs for the instrument. A computer program for data entry and case reporting automates the scoring of the instrument, facilitates the inevitable move to paperless recordkeeping and electronic data communication, and provides aggregate data[2] for population descriptions, internal accountability, and reports to funding and licensing agencies. In addition, aggregate case data can sometimes persuade funding and governmental agencies responsible for resource allocation that a serious need exists for expanded local resources for adolescents.

The training required for the screening assessment should be minimal. Screening should be quick, efficient, and designed to be "oversensitive" to AOD abuse, acknowledging even possible evidence of AOD use. Furthermore, and perhaps most important, the screening assessment should be suitable for and integrated into the standard procedures used by all individuals in the community who will come into contact with troubled adolescents. Training should illustrate how such factors as race, culture, gender, socioeconomic status, and other life experiences can have an impact on the screening process. Training should also include an understanding of today's families, as discussed above.

The results of the screening assessment, if suggestive of possible AOD abuse, should go directly to the agency responsible for the more intensive treatment planning assessment. (Knowing which agency is responsible for treatment requires training.) This should be part of the standard operating procedure for all affected individuals, agencies, organizations, and departments.

Multifaceted Approach

The need for a multifaceted approach in adolescent AOD screening and assessment is important because:

- Many different people who may be able to detect AOD abuse come into contact with a young person.
- Adolescent AOD abuse often involves problems in more than one area of the young person's life (such as school, home, or community).

- **Chapter 3: Comprehensive Assessment of Adolescents.**

This chapter describes the comprehensive assessment recommended for adolescents with AOD abuse problems, including the purposes of the assessment, the target population, the types of workers who should do the assessment, and what should be done with the results of the assessment.

There are three reasons to carry out a comprehensive assessment on adolescents with suspected AOD abuse after an initial screening has been performed:

1. To determine if the evidence for AOD use seen in the initial screening holds up in a more in-depth assessment,
2. To determine how serious the youth's other problems related to the AOD abuse may be, and
3. To plan for an effective and appropriate intervention.

The target population includes adolescents who have been identified in the screening interview.

The appropriate evaluator is a responsible and trained professional from any of several disciplines such as guidance counseling, substance abuse counseling, clinical psychology, social work, medicine, or nursing. Since this comprehensive assessment will require intensive and sophisticated evaluations on several levels (for example, psychiatric diagnosis, family relations evaluation, and literacy), there is need for sensitivity, professionalism, and experience in the performance of these assessments. It is also important for the evaluator to be knowledgeable about adolescent AOD issues.

If the results confirm AOD abuse, an appropriate intervention—such as a treatment program, remedial education, family counseling, etc.—should be initiated. Again, if treatment or another type of intervention is indicated, it is the ethical duty of the assessor to see to it that her or his recommendation is followed.

- **Chapter 4: Legal Issues in the Screening and Assessment of Adolescents.**

This chapter explores subtle, complicated issues concerning the sharing of information with parents and guardians, on the one hand, while protecting the adolescent's right to confidentiality on the other; privacy; confidentiality; the need to know; and appropriate and inappropriate situations for the release of information.

- **Chapter 5: The Screening and Assessment of Adolescents in Juvenile Justice Settings.**

This chapter explores the special cautions and specific obligations to the adolescent that pertain to assessment and treatment of youth within the JJS. It also discusses strategies within the JJS for maximizing effective information collection and utilization to benefit the adolescent.

- **Appendix A, Part 1. Description and Review of Assessment Instruments for Alcohol- or Other Drug-Abusing Adolescents**—is a compendium of information taken from a document prepared by the National Institute on Drug Abuse (NIDA) entitled "Assessment Instruments for Drug-Abusing Adolescents and Adults." This version is an abridgement of the portion pertaining to instruments for assessing adolescents. An introduction provides the reader with a more in-depth understanding of many assessment terms used throughout this TIP.
- **Appendix A, Part 2**—explores Additional Instruments Reviewed by the CSAT Consensus Panel.
- **Appendix B: Monograph: Drug Testing of Juvenile Detainees**—is a reprint of a monograph prepared by the American Correctional Association and the Institute for Behavior and Health, Inc., under a grant from the Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, U.S. Department of Justice. It is preceded by comments about an amendment to the Clinical Laboratory Improvement Act (CLIA-88) which became effective in September 1992 and which regulates medical testing done in physicians' offices, hospitals, nursing homes, or satellite medical facilities.
- **Appendix C: Psychoactive Substance Use Disorders Defined by the American Psychiatric Association**—is a reprint of a chapter from *Diagnostic and Statistical Manual of Mental Disorders*, Third Edition Revised, published by the American Psychiatric Association (Washington, D.C., 1987). A revision of this document is currently being prepared and will be published in 1994. It may include revisions to the chapter reprinted here.
- **Appendix D: Sample Instruments**—includes a few instruments to help readers unfamiliar with assessment gain a greater understanding of the processes used to evaluate adolescent AOD abuse. It is hoped that reviewing actual instruments will assist the reader in learning as much as possible from this TIP.

Conclusion

AOD abuse and related problems rank among society's most pressing concerns. Although this volume focuses on assessing the individual youth's problems as a foundation for treatment, programs involved with adolescent AOD abuse should also be a part of efforts to assess and remediate the fundamental community and societal problems that have an impact on troubled youth.

The importance of program involvement in broad community action is also discussed in a companion TIP on adolescent AOD abuse treatment. The changes needed to support all young people in leading healthy and productive lives require the active commitment of adults on many levels of intervention. Community action is an integral part of many screening and assessment issues. It is a concern that should be kept in mind at all times.

AOD Assessment

- Assessment is a broad term.
- It includes a range of evaluation procedures and techniques.
- It measures key areas of the youth's functioning.
- It measures key aspects of the youth's environment.
- It is not a single event, but a series of different types of techniques applied at different times for different reasons.

Endnotes

1. Instruments: In this context, instruments are tools (including written questionnaires, etc.) used to evaluate AOD use and treatment.

2. The term "aggregate data" refers to the sum total of all the individual data for a particular measure or scale for a youth population.

Chapter 2—Preliminary Screening Of Adolescents

Purpose of Preliminary Screening

Early identification of alcohol and other drug (AOD) problems among adolescents, followed by appropriate in-depth assessment and the right type of intervention at the community level, increases the quality of life and participation in society of young adults. Furthermore, such early identification and intervention can help to reduce both long-term care needs and the burden on the criminal justice system, thereby lessening long-term costs. Thus, preliminary screening—the first step in a series of steps in caring for potential or active AOD-abusing adolescents—makes both social and economic sense.

The central principle underlying this chapter is that all adolescents who exhibit markers of AOD abuse deserve appropriate, valid, and sensitive screening regarding AOD use. Community organizations (e.g., schools, health care delivery systems, the judiciary, vocational rehabilitation and religious organizations) and individuals associated with adolescents at risk must be able to screen and detect AOD abuse. They must also refer adolescents for further assessment in a timely manner. In order for this to happen, linkages must be made within the service community.

Preliminary screening is the first in a series of different assessments and interventions. Adolescents identified because of problems in school, on the job, in the community, with the law, and so on should be screened. When screening turns up "red flags" that indicate that the adolescent may have serious AOD problems, the youth should be referred for comprehensive assessment. In recognition of the importance of early detection and intervention, it is appropriate to be inclusive in identifying youths for preliminary screening and in conducting the screening. It is in the comprehensive assessment that a diagnosis of substance abuse is made and recommendations for intervention are developed. The comprehensive assessment will, among other things, screen out youths who do not require AOD services. A comprehensive assessment may conclude that although there has been some evidence of possible AOD use, there is no need for further intervention.

Individuals carrying out preliminary screening must be sensitive to the danger of being too

The Importance Of Screening and Assessment

Early identification of adolescent AOD problems, followed by appropriate assessment and intervention, has the potential for accomplishing the following:

- Enhancing and improving the young person's quality of life
- Increasing the young person's participation in society
- Reducing long-term care needs
- Reducing burden on the criminal justice system
- Lessening long-term care costs
- Providing cost effective referrals for needed services.

quick to identify an adolescent as an AOD abuser. Only by successful implementation of the full screening and assessment continuum can practitioners be reasonably sure that an adolescent needing AOD services has been appropriately identified.

The screening process should be centered on the adolescent and should be holistic—in other words, it should look at every aspect of the young person's life. The screening process should indicate whether the adolescent has other problems—either visible or incubating—that must be identified. Within the limited time available to most agencies, the preliminary screening should take into account a variety of factors and data sources, including the youth's individual strengths; the home and living situation of the youth; the youth's relationship to the child welfare system and the juvenile justice system; the youth's relationship to the school system and educational history; the youth's involvement with the mental health system; the family's history of AOD abuse or mental health problems; and the youth's medical status. It is important that the screening and assessment processes address the youth's motivation for treatment, as well as his or her resistance and denial. Strategies will need to be developed to deal with these matters.

People involved in preliminary screening or comprehensive assessment should receive training on HIV/AIDS prevention, education, and treatment among the adolescent population. Knowledge of the risk of HIV infection is essential when working with troubled youth or their families. Youths who have multiple sex partners or who use drugs intravenously are at high risk for being infected by, or transmitting, HIV. Comprehensive histories regarding the young person's sexual and drug history should be part of the comprehensive assessment process. Youths needing further assistance with an HIV problem should be referred for additional evaluation. Agencies should have policies and procedures regarding the provision of information to youth regarding HIV counseling and testing. For instance, if the assessment process reveals that a young person has engaged in high-risk behavior, the assessor should know whether or not the youth should receive HIV counseling and testing, and where and how this should be conducted. Agencies must have policies in place with regard to confidentiality and the HIV status of the clients being served. Such policies must include procedures with respect to recordkeeping and identifying who has the "need to know" the HIV status of a client. (For instance, each agency should decide whether the assessor should know the HIV status of the client.) Confidentiality policies must be in compliance with Federal and State laws.

In order for all potential substance-abusing adolescents to receive appropriate screening, the variables of age, ethnicity, culture, gender, sexual orientation, socioeconomic status, and literacy level must be considered in the design and implementation of the screening process as well as in the interpretation of the screening results. Preliminary screening instruments should reflect an appreciation of considerations such as age, socioeconomic status and other demographics, culture (and, where indicated, degree of acculturation), gender-specific issues, sexual orientation, and literacy level. Instruments must be designed with sensitivity to differences in adolescents' backgrounds, and the people who administer the instruments and related interviews must be sensitive to these considerations as well. At the same time, assessors and those who design and use screening instruments should recognize the range of variation between and among groups. That is, they should recognize that, within a given ethnic group, families will vary in their degree of acculturation, socioeconomic status, and lifestyle.

Key Issues in Adolescent AOD Screening

- All aspects of the screening process should be sensitive to ethnic, cultural, socioeconomic, and gender-related concerns.
- All youth that exhibit markers should be screened.
- Screening should pick up "red flags".
- A wide range of people should be able to conduct screens.
- Screening is the first step toward referral.
- Information on the young person should be gathered from many people.
- A variety of factors should be taken into account in the preliminary screen (see text).
- Youth, screeners, and the community should be involved in the development of the screening process.

Instruments used should have normative data available for different cultural groups. Because social, cultural, and political factors are involved in screening adolescents for substance abuse, people from a wide range of cultural, ethnic, and socioeconomic backgrounds should be involved in all stages and aspects of the screening process.

Components of Preliminary Screening

There are at least three aspects of preliminary screening: 1) the screening instrument; 2) drug monitoring; and 3) the collection of information from different sources, including the family.

Preliminary Screening Instruments

The first of the three parts of the preliminary screening is the administration of a short, simple screening interview. The questions should be appropriate to the youth's age. The instrument gives the "big picture" of the youth's situation, but not a lot of specific, detailed information. However, the instrument should be of sufficient scope to tap key areas of psychosocial functioning that relate to AOD problems. The instrument should be designed to pick up on "red flags"—warning signs for adolescent AOD abuse. (See "Red Flags" below.)

The instrument should be easy for a broad range of professionals and paraprofessionals to understand and administer, so that it will be more likely to be widely used by agencies. A brief, carefully crafted instrument can help overburdened agencies to serve more clients more effectively. To enable a wide range of staff to use the screening instruments, training should be provided at the community level. Interviewers should receive training in rapport building, developing trust, and cultural sensitivity.

All the language used in the instrument should be selected with sensitivity and care. Language used should be nonpejorative: in other words, the words should not belittle the youth, but should be specific to the youth's behavior. Perhaps most important, the language should reflect an appreciation for the developmental phase of the young person. (For example, the situation of a 7-year-old who takes a drink is different from that of a 17-year-old.)

In developing standardized instruments and protocols for preliminary screening, it is often wise to involve youth representatives. Youth who have been involved in substance abuse treatment systems with success in rehabilitation may have a keen insight into key issues, as well as language, relevant to the development of materials. Likewise, personnel who will administer the screening should be included in the development of standardized documents. Assessment professionals should be represented, too, in the process of developing screening instruments.

The consensus panel reviewed screening and assessment instruments for adolescent AOD use. Assessment instruments are described in Appendix A, but are not necessarily appropriate for preliminary screening as described in this document. For example, the "Prototype Screening/Triage Form" (Dembo et. al., 1990) covers appropriate areas but is too long to be useful in preliminary screening. It also requires training to administer, and needs a skilled interviewer to score and interpret. Some of the tools, such as the Personal Experience Screening Questionnaire (WPS, 1991) are shorter and easier to use but focus too specifically on AOD abuse and do not collect information on other "red flags." Other tools reviewed are appropriate for consideration in assessment after screening, but are impractical as screening devices because of their length, complexity, cost, and overly comprehensive data collection. These instruments may provide suggestions for appropriate areas to evaluate and items to include.

The Problem-Oriented Screening Instrument for Teenagers (POSIT), developed by the National Institute on Drug Abuse (NIDA) in 1987, is recommended for consideration as a preliminary screening tool. It requires only 20 minutes to administer, requires no training, and is easy to score and interpret. Yet it covers 10 potentially problematic areas that NIDA has identified as necessary to cover in a preliminary screening.

The reader is encouraged to use Appendix A in developing a particular instrument that will meet the specific needs of the organizations in the community that will use it. It will be particularly important for all agencies in the community to agree to use the same instrument, to be trained in the use of the instrument, and to understand appropriate referral procedures when sensitive findings are revealed.

Screening should not be driven by the screening instrument, but rather by the need to identify treatment and intervention needs of the youth and family.

Drug Monitoring

Drug monitoring should *not* be used as a screening instrument; rather, it is used in the preliminary screening to supplement information gathered through the use of the simple screening tool and additional sources. Drug monitoring should be conducted at an appropriate point during screening consistent with accepted standards and guidelines. Drug monitoring through such methods as urinalysis, hair testing, and saliva tests, when performed by someone with proper training, is

often the quickest, most accurate way to detect recent drug or alcohol use. Drug tests should be used for clinical rather than forensic purposes.

The Family and Other Supplementary Sources of Information

To supplement and corroborate the information gathered through interview with the screening instrument, data should be collected from interviewer observations, the youth, the youth's family, available case histories, and other sources. These sources include people working within the juvenile justice, child welfare, or school system; clergy; peers; family (including siblings and nontraditional family members); and the health care system. Getting information from different people will help the assessor to guard against developing an incorrect picture based on the young person's denial, misrepresentation, or minimization of the situation. When possible, providers should verify data with several sources of information.

The youth's family should be involved to the maximum degree possible in the assessment process, in the formation of a realistic treatment plan, and in the treatment process. To the extent possible, the family probably should be screened immediately after the screening of the adolescent, with his or her consent. Some components of the screening will need to be conducted with the youth in the room and some with the youth out of the room. However, when there are indications that the family is a factor contributing to the youngster's problems, family involvement should be appropriately structured.

Sources of Information

Collateral sources can include people or information from the following areas:

- Family members
- Health care system
- Juvenile justice system
- Clergy
- Child welfare system
- Peers
- School system
- Employers.

Using the family as a data source presents some complex issues. Where preliminary screening is suggested to identify a child at high risk, is it appropriate to involve the family? Does the program have the necessary resources to explore different significant others who constitute the young person's family, some of whom may also be in need of support or intervention?

In looking at the family, assessors should ask two questions: What does one need to know from the family to help the child? and, What does one disclose to the family while treating the child? Assessors also need to be reminded of the duality of their role. They are gathering information that has the potential to force them to make some determination about the ability of individuals in the adolescent's life to parent. This information could result in the removal of the adolescent or other children from the home. Nonetheless, every effort should be made to involve the family in the assessment process as soon as possible to help family members interact positively with an adolescent being assessed or receiving services.

Assessors should also recognize that, in some instances where decisionmaking authority for the adolescent may have been removed by the court, one or more members of the family could still be involved with the adolescent, given an opportunity. Assessors must resist the assumption that where there is a delinquent adolescent, there is an incompetent family.

Family Involvement in AOD Screening
Ethical and Legal Considerations

The following questions should be kept in mind by program staff or administrators:

- Has the young person consented to family involvement?
- Has the screener decided the point in the screening process at which the family should be involved?
- Does the program have the resources to provide some form of support or intervention to the family, if needed?
- Has staff been given training on family systems?
- What does the screener need to know from the family to help the youth?
- What information does the screener give the family when screening the youth?
- Has the screener looked for the family's strengths?
- Is the screener aware of the youth's definition of his or her family as well as the youth's legal caretaker?

Staff to be involved in screening and assessment need specialized training in working with families that have been affected in some way by an AOD abuse problem. Some examples might be chemically dependent family systems; families in which there is significant dysfunction secondary to issues other than chemical dependency; or families that have been affected by a family member who is suffering from a chronic disease such as sickle cell anemia, cancer, multiple sclerosis, or AIDS. Furthermore, the individual responsible for assessing families should have had some period of direct supervision by a professional who is knowledgeable in family assessment and family functioning. Staff should be given appropriate training to understand the definition of family as described in this volume.

Who to Screen: Knowing The "Markers"

Participating community organizations and individuals should be informed, through training, about significant markers that may indicate AOD abuse. Youths who exhibit these markers should be referred for preliminary screening. These indicators include (at the very least):

- Involvement with the juvenile justice system;
- Marked changes in psychological state;
- Abrupt changes in family and school functioning (behavioral, emotional, and academic);
- Observations of physical symptoms such as abnormal sleep patterns, agitation or depression, personal hygiene, etc.;
- Movement toward less functional peer relationships such as gang affiliation;
- Presence of drug paraphernalia;
- Increase in aggressive behavior or behavior in which the youth is frequently at odds with family, friends, and those in authority;
- Running away from home, or homelessness; and
- Parental incarceration.

These markers may show up in any of several ways. For example, within a school, a youth who shows significant changes in grade point average within a given period of time and more than a stated number of unexcused school absences might be referred for screening. Juvenile justice authorities might screen adolescents at the time of arrest or detention. A dramatic behavior change—withdrawal, aggression, petty theft, drunk driving, or truancy—may signal a problem. Physicians and health care workers might screen adolescents who present with substantial behavioral changes or emergency medical services for trauma, or who suddenly begin experiencing medical problems such as accidents, injury, or gastrointestinal (stomach-related) disturbance. However, it is important to rule out physical causes for these behavior changes. Thyroid problems, for example, can be mistaken for psychological disorders.

Red Flags: Indicators of the Need for Comprehensive Assessment

The screening instrument should be sensitive to "red flags"—indicators of serious AOD-related problems that have been identified by clinical experience. (More research is needed on red flags for AOD abuse.) If the assessor observes any one of the red flags described in the box that follows, the adolescent should be referred for comprehensive assessment:

Indicators for Assessment

- Physical or sexual abuse
- Parental AOD abuse
- Parental incarceration
- Poor school performance or attendance
- Physical symptoms of AOD abuse or adverse consequences of AOD abuse
- Peer involvement in AOD use or serious crime
- Marked change in physical health
- Involvement in serious delinquency or crimes
- Dysfunctional family relationships
- Serious problems at work (e.g., losing a job) or in school
- Marked changes in physical health
- HIV high-risk activities (e.g., intravenous drug use; sex with intravenous drug user)
- Indicators of serious physical problems (e.g., suicidal ideation, severe depression).

The Need for Community Coordination

In too many geographic areas throughout the nation, caring for adolescent AOD abuse problems is not a priority, and there are often too few resources to meet the growing need for both screening and treatment. Often, at-risk behavior among youth is viewed solely as a disciplinary problem. On the other hand, such behavior can be viewed as a signal from the youth that intervention is needed. Community-based training and community involvement in the screening process can go a long way toward enhancing effective community responses to AOD-involved youth.

Agencies should establish an areawide coordinating committee for adolescent screening and assessment. The areawide coordinating body should review and select reliable, standardized screening and assessment tools from among the instruments presented in the TIP that will give sufficient standardized information to all agencies serving the same youths and their families. These should be tools that the State, county, or metropolitan area can include in an assessment battery. Then the battery can be refined from feedback gained from focus groups. Community agencies should be encouraged to collect norms on the standardized instruments that comprise their core assessment battery.

AOD, mental health, and related service providers and other community agencies specifically designed to serve youth at risk should agree to use the same screening instruments and procedures, tap the same problem areas, and use the same referral criteria as much as possible. Communities should develop agreed-upon thresholds for referring young persons for additional comprehensive assessment. Groups and individuals should define "high-risk" behavior for their particular community.

Agreement on such issues will empower the agencies to work in the best interests of youth. Agreement should be the result of community-level consideration of the concerns and the community's best process for responding to the problems. Key agencies in the community (e.g., law enforcement, the schools, voluntary and public child welfare agencies, human service agencies, and juvenile justice agencies) should all be a part of this discussion. The process might blend community networking with meetings that encourage agencies to work together or collaborate on service delivery efforts.

Administrative considerations regarding preliminary screening include such factors as cost; ease of use; flexibility in use in different settings among different populations; analyses of screening data; and preparation of relevant reports. To address these considerations, there must be active coordination among agencies throughout the community or local area. A communitywide interagency mechanism should be put in place for coordination and implementation of screening, management of information systems (MIS), and training of screeners.

Ways to monitor quality assurance should be developed to determine the effectiveness of the coordinating body and to enhance the comprehensive assessment process. Data for technical assistance and funding purposes should be provided to State AOD agencies.

The establishment of an areawide coordinating body for adolescent AOD abuse screening and

Community Involvement Needed In All Aspects of Adolescent AOD Screening and Assessment

- Adolescent at-risk behavior: a wake-up call for community action!
- Community representatives should define what "high-risk" means.
- Community representatives should create an areawide coordinating committee for adolescent AOD screening and assessment.
- Community representatives should develop protocols for:
  - AOD screening, and
  - Referrals for in-depth assessment.
- Agencies should work together to establish ongoing collaborative relationships via some form of structured community interagency mechanism.
- Key community agencies should be involved in both the areawide coordinating committee and the interagency mechanism. This includes agencies involved in adolescent education, law enforcement, child welfare, public health, and mental health.
- Screening results should be compiled on a communitywide basis.
- Management information system (MIS) tracking based on compiled data should be instituted.
- Screening results should be used to stress the need for additional adolescent AOD abuse treatment services.
- Community coordination should strive to empower agencies to develop programs and systems to meet the needs of troubled youth and their families.

assessment could greatly facilitate administrative effectiveness on all levels. The Treatment Alternatives to Street Crime, or TASC, programs offer one example of effective interagency collaboration. In addition, the establishment of a communication mechanism between agencies would go a long way toward improving administrative difficulties.

Communitywide efforts to establish centralized adolescent intake, screening, and processing centers have increased in recent years. An example of this trend is the Juvenile Assessment Center in Tampa, Florida.

In the development of coordinating mechanisms for screening and assessment, thought must be given to the way these processes can be integrated into coordinating mechanisms for adolescent AOD abuse treatment. In other words, when looking at community coordination efforts concerning adolescent AOD abuse, screening and assessment must both be taken into consideration.

Funding for grassroots training and implementation is necessary to support communitywide collaboration. Training should take place within a particular agency, among different agencies, and areawide. Such efforts will help to identify the service providers most likely to conduct preliminary screening (for example, protective service and intake workers, guidance counselors, nurses, etc.). Special strategies may need to be developed to respond to the service needs of adolescents living in small or rural communities.

Screening results should be made available to a large repository that can track data through on-line computer and data-based systems. MIS tracking, based on compiled data, can provide information critical to future planning. (Due to lack of resources, some communities will not have the capacity to conduct these efforts.)

Often, adolescents are screened and recommendations made, but there are no services available to meet their needs. All screening data can be compiled and used to demonstrate service needs and to advocate for resources. Having coordinating bodies in place at areawide and interagency levels should be a great help in this advocacy process. Communities must recognize that identifying AOD-abusing adolescents in the absence of appropriate treatment resources raises serious ethical concerns. Thus, the results of preliminary screening should be used to make supply-and-demand connections at the social policy level.

Ethical Considerations Related to Preliminary Screening

This chapter has discussed a number of ethical principles that should guide preliminary screening. Several additional legal and ethical considerations are also vitally important. Such concerns include informed consent, confidentiality, privacy, availability of services, and reporting mechanisms. Confidentiality is especially relevant with regard to revealing information to parents or guardians, interagency communication, and long-term recordkeeping (including the issue of who has access to the information).

Adolescent AOD Screening
Ethical Considerations

Remember the following ethical issues when conducting preliminary AOD screening of youth:

- Explain to the young person what is taking place in terms he or she understands—informed consent is a legal requirement.
- Confidentiality and privacy must be a program priority—always!
- Do not label the young person.
- Words used in a young person's files can follow him or her around for many years to come—be careful!
- Report facts, not opinions.
- Suspect parental abuse or neglect? Know and understand reporting requirements.
- A variety of questions related to the family must receive attention (see text).

Follow any positive results with a comprehensive assessment.

Informed consent is a critical area in screening, as in comprehensive assessment and treatment. Informed consent involves explaining the process to the adolescent in terms that she or he can understand (a process that can be difficult enough to achieve when the patient is an adult). It is quite a challenge for adults to give clear and realistic explanations to a troubled young person.

Both Federal and State regulations stipulate that patients must know their rights. In many instances, a child has the right to veto the release of information. (Refer to chapter 4, "Legal and Ethical Issues in the Screening and Assessment of Adolescents," for a full discussion of a youth's right to informed consent before any information can be released, and the situations where his right is limited.)

How information is stated and stored in the files is critical, especially in today's world of computerized recordkeeping. Once a file is created, it can "follow" a client for the rest of his or her life. Wording can lead to misinterpretation, creating future problems. Labeling of the adolescent must be avoided. One way to avoid labeling is to report facts, not opinions.

Where abuse or neglect of the adolescent is suspected, duty-to-report requirements, which vary from State to State, must be known, understood, and complied with.

Protocols developed by community agencies to govern screening and assessment must also be clear about consent and patient notice, confidentiality and privacy, State and Federal regulations (including those regarding child abuse reporting), and duty-to-warn requirements. Confidentiality and privacy will become realities for youth served by a program only if specific guidelines are established and followed regarding administrative procedures, training, and more. In other words, confidentiality and privacy must be highlighted as priorities in every aspect of the program. Training must be provided so that protocols and instruments are clearly understood. Interviewers must remind clients in a clear, realistic, and understandable manner about their rights concerning informed consent, privacy, and so forth.

Refer to chapter 4 for a more detailed discussion of legal concerns.

Chapter 3—Comprehensive Assessment of Adolescents For Referral and Treatment

The Purposes of Comprehensive Assessment

Alcohol and other drug (AOD) abuse rarely occurs in isolation. Academic weaknesses, personality issues, psychosocial problems, and difficult family relationships are frequently present—not to mention problems in the community and society that contribute to AOD abuse, such as poverty, unemployment, and the availability of drugs. These problems may help to start AOD abuse, they may result from drug use, or they may be problems that briefly stand apart from other circumstances. Regardless, the number and severity of these problems will usually have an important effect on the development of the AOD abuse treatment plan, the delivery of services, and the eventual outcome of the intervention.

As noted in chapter 1, the significant physical, cognitive, emotional, and social transitions that an adolescent goes through from the early to late teens, and the variations among adolescents of the same chronological age, dramatically increase the complexity of the assessment process.

Comprehensive assessment is a process that begins following the initial identification of potentially affected adolescents and before the startup of more long-term intervention efforts such as treatment. Just as screening procedures can identify a youngster who may have a significant AOD problem, the comprehensive assessment helps determine the nature and complexity of the adolescent's spectrum of problems. Comprehensive information can be used to develop an appropriate set of interventions.

Why Do Assessments?

- AOD abuse rarely occurs in isolation.
- Many factors in the youth's life are related to AOD abuse.
- The nature of the other problems in the youth's life affects the treatment plan and service delivery.

The comprehensive assessment has several purposes:

1. To accurately identify those youngsters who are in need of treatment, so that limited resources are not misdirected. (Advocacy for additional treatment resources is also appropriate.)
2. To determine the severity of the AOD problem(s) identified by the screening process.
3. To permit the evaluator to learn more about the nature, correlates, and consequences of the youth's AOD behavior. In addition, the assessment begins a process that will allow treatment to respond creatively to the youth's denial and resistance. The assessment can be seen as an initial phase of the treatment experience.
4. To ensure that additional related problems not flagged in the screening process are identified. Examples include problems in medical status, psychological status, social functioning, family relations, educational performance, and delinquent behavior.
5. To examine the extent to which the youth's family (as defined in the introduction to this volume) can be involved not only in comprehensive assessment, but also in possible subsequent interventions.
6. To identify specific strengths of the adolescent (e.g., coping skills) that can be used in developing an appropriate treatment plan.
7. To develop a written report that:
   - Identifies the severity of the AOD abuse,
   - Identifies factors that contribute to or are related to the AOD abuse,
   - Identifies a corrective plan of action to address these problem areas,
   - Details a plan to ensure that the treatment plan is implemented and monitored to its conclusion, and
   - Makes recommendations for referral to agencies or services.

The Multiple Assessment Approach

No single factor causes drug abuse. "Instead, drug abuse develops from the interaction of multiple influences including biological, psychological, social, and environmental factors" (Glantz, 1991). This varied pattern of influences necessitates a comprehensive review of different personal areas in the youth's life, rather than a focus on AOD use alone. Such a review will improve the accuracy of diagnosis and treatment referral.

This assessment process is called *the multiple assessment approach.* It involves collecting information through interview, observation, specialized testing, and the use of evaluation, treatment, and case documentation. The assessment should be conducted according to local, State, and Federal laws and guidelines regarding confidentiality and child abuse reporting. Exhibit 1 provides a schematic representation of the multiple assessment approach.

In some agencies, child abuse reporting is handled by a single clinical manager; in others, it is handled through consultation with peers and supervisors. There is a need, on the one hand, to guarantee the immediate safety of the adolescent or other children in the home and to comply with the legal implications of child abuse. On the other hand, however, there is a need to avoid sacrificing or straining the trust that must develop between the assessor and the adolescent. Assessors must be aware of local procedures and standards, and must handle their obligations with sensitivity.

The types of assessment procedures, assessment instruments, access to key informants, and involvement of the family will vary according to procedures in place locally and the individual youth involved. (The assessment process will also vary with the agency and the person doing the assessment.)

Multiple Assessment Approach

The comprehensive assessment process for adolescents with AOD problems should involve many different approaches, such as:

- Interviews
- Observations
- Specialized testing and physical exam
- Review of previous evaluations, treatment, and case documentation
- Family interviews
- Family involvement and access to other key informants.

The assessment process is always confronted with practical constraints such as the lack of time and resources. The choice of procedures and instruments must be sensitive to these practical constraints. In a situation where the assessor feels that the available resources will not support a treatment recommendation, he or she is obligated to discuss this with the adolescent and the family or guardian, as well as documenting the limited resources. However, every effort should be made to place youth in the best available form of needed intervention. Good documentation by the assessor of inadequate local resources for assessment can be used to lobby for expansion of these resources. (See chapter 2 recommendations regarding the importance of community coordination to see that needs for service are met.)

Domains to be Assessed

Many domains can be assessed. (See Exhibit 2.) They include:

1. Strengths or resiliency factors including self-esteem, family, other community supports, coping skills, and motivation for treatment.
2. History of use of AODs, including over-the-counter and prescription drugs, tobacco, and caffeine. The history notes age of first use; frequency, length, and pattern of use; and mode of ingestion.
3. Medical health history and physical examination (noting, for example, previous illnesses, infectious diseases, medical trauma, pregnancies, and sexually transmitted diseases). An adolescent's HIV status—positive or negative—should be assessed with the adolescent's consent but not be noted in the young person's records. Also, assess HIV high-risk behavior and refer to sexual history.
4. Developmental issues, including influences of traumatic events (such as physical or sexual abuse).
5. Mental health history, noting depression, suicidal ideation or attempts, hallucination, etc., should include previous evaluation and treatment summaries, if available.
6. Family history, including the parents' and/or guardians' history of AOD use, mental and physical health problems, chronic illnesses, incarceration or illegal activity, child management concerns, and the family's cultural, racial, and socioeconomic background and degree of acculturation. The description of the home environment should note substandard housing, homelessness, proportion of time the young person spends in shelters or on the streets, and any pattern of running away from home. Issues regarding the youth's history of child abuse or neglect, involvement with the child welfare agency, and foster care placements are also key considerations. The family's strengths should also

Exhibit 1

Assessment Process

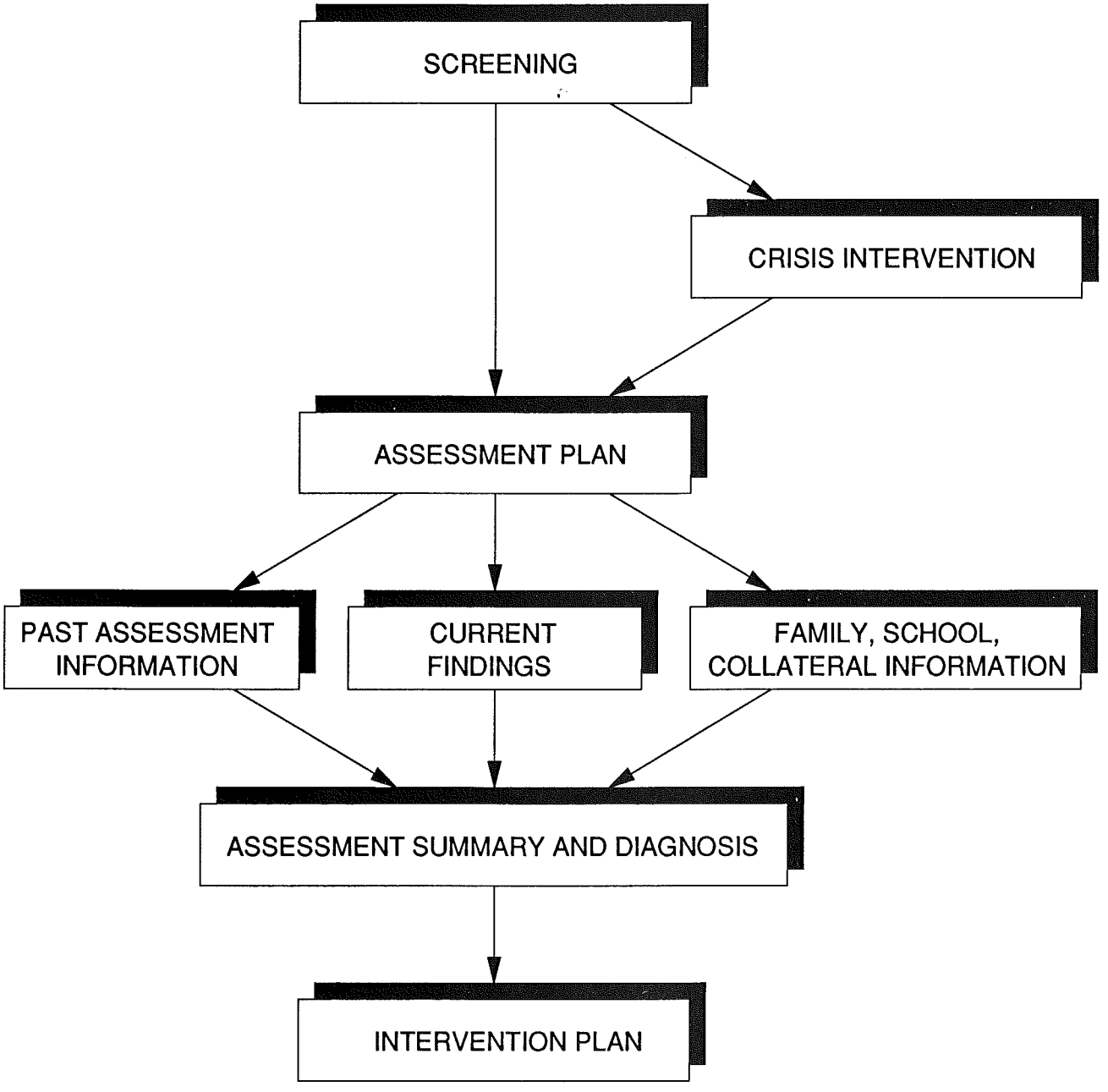

Exhibit 2

Assessment Domains

The following are examples of possible "domains" or topical areas in a young person's life to examine when conducting a comprehensive assessment of AOD abuse.

- Alcohol and other drug use
- Over-the-counter and prescription drugs, including tobacco and caffeine
- Medical history:
  Previous illnesses, infectious diseases, medical trauma, STDs (sexually transmitted diseases, with the exception of HIV status, which requires special training and agency protocols)
- Mental health history, including:
  Previous evaluations, treatment summaries
- Family history
  Strengths as well as problems; AOD abuse; mental and physical health problems, including chronic illness(es); involvement with juvenile or justice system; child management concerns; an understanding of the family's cultural, racial, and socioeconomic background
- School history:
  Learning-related problems, academic performance, behavioral performance, and attendance
- Vocational history:
  Paid work, volunteer work in community
- Child welfare involvement:
  Number and length of foster home placements, residential treatment
- Juvenile justice involvement:
  Types and frequency of involvement, attitude toward behavior that got him or her in trouble
- Sexual history:
  Sexual abuse, sexual activity, safer sex practices, current or previous
- Peer relationships
- Gang involvement
- Interpersonal skills
- Leisure-time activities
- Neighborhood environment
- Home environment, including:
  Substandard housing; family history of homelessness; the young person's living on the streets or in shelters, or running away from home.

be noted as they will be important in intervention efforts.

6. School history, including academic and behavioral performance and learning-related problems, and attendance.
7. Vocational history, including paid and volunteer work.
8. Sexual history, including sexual abuse, HIV risk behavior, and sexual orientation. (Individuals with responsibility in the assessment process will need special training on HIV and adolescents.)
9. Peer relationships, interpersonal skills, gang involvement, and neighborhood environment.
10. Juvenile justice involvement and delinquency, including types and incidence of behavior and attitudes toward that behavior.
11. Social service agency program involvement, child welfare involvement (number and duration of foster home placements), and residential treatment.
12. Leisure-time activities, including recreational activities, hobbies, and interests.

The Role of the Assessor

The assessor can be any appropriate professional experienced with adolescent AOD issues—a psychologist or mental health professional, school counselor, social worker, nurse, physician, substance abuse counselor, or any other individual in the private or public sector with responsibility involving an area of the adolescent's life. (For example, the assessor might work in private practice, a public clinic, or a nonprofit organization.) The assessor should also have sufficient experience in evaluating youths with AOD problems to be able to perform quality assessments.

One individual should take the lead in the assessment process, especially with respect to gathering, summarizing, and interpreting the assessment data. If the responsibility is spread out, the adolescent may "fall through the cracks" or tasks may be duplicated unnecessarily. (The process of coordinating the activities of different people and agencies working with a young person is often difficult. It can involve interagency meetings, turf questions, and the like.)

The skill level of the assessor should be appropriate to the tasks required by the assessment process and the particular training needed to use the specific instruments. For example, an unlicensed but trained technician may administer an objective assessment instrument such as those discussed in Appendix A, the results of which may need to be interpreted and confirmed by a licensed psychologist, psychiatrist, certified substance abuse counselor, or other mental health worker. The assessor should be trained and qualified to administer every instrument in use within his or her agency or office, with regular updates and continuing education as needed.

Note that the training, education, accreditation, sensitivity, and skill level of the assessor can limit the scope and outcome of the assessment. An assessor not licensed to make mental health diagnoses should refer an adolescent in apparent need of a formal psychiatric workup to an appropriate professional. Other professionals should be involved in the assessment process if assessors are not comfortable with or trained in particular types of issues (such as physical or sexual abuse, medical problems, sensitive family issues, or cultural concerns).

By accepting responsibility for the assessment of an adolescent (and, to the extent possible, her or his family), the assessor also accepts responsibility for developing a plan of corrective action. If the existence of a problem or problems in the adolescent is confirmed, the assessor should also develop a treatment plan of recommended intervention(s) and monitor its implementation. Linkages with various local agencies and programs should be established to guarantee that the adolescent will be properly transferred from assessment to the recommended referral or service

Taking the Lead In the Assessment Process

- One person should take the lead in the assessment process.
- Spreading the responsibility for assessment can allow youth to "fall through the cracks" or unnecessarily duplicate effort.
- Turf questions must be resolved so that coordination can occur.
- Interagency meetings may be needed to coordinate the assessment process.

agency and receive the services he or she needs.

Therefore, the assessor should not be a passive link in the chain from screening to treatment. Instead, active efforts by the assessor to foresee possible snags in the process (regarding arrangements for referral and screening and dealing with service professionals and agencies) can make a big difference in the success of each adolescent's case. In other words, to ensure that the youth obtains needed services, the assessor often must become the young person's advocate. The assessor may frequently face challenges in obtaining needed services. These barriers include limited family financial resources, a shortage of slots in AOD programs, agency turf issues, and lack of appropriate services for specific treatment needs. These issues can be addressed by community networking, interagency communication and collaboration, and systematic data gathering to document adolescent treatment needs.

Setting

The assessment should be conducted in an office or other site where confidentiality can be ensured and where the adolescent can feel comfortable, private, and secure. It is obvious that the validity of information provided by the youth may depend on the setting (especially if the setting is seen by the youth as adversarial or threatening), the level of trust between the adolescent and the assessor, and the adolescent's understanding of the potential use and audience for the information he or she is about to divulge.

If the adolescent feels that he or she is going to be overheard by others in the assessor's office or that providing information will result in punishment, it is unlikely that the full truth will be told. If an interview is conducted in a detention center, it is essential that the juvenile perceives that no one in authority at the center can overhear the interview.

If other people, such as the youth's family, are involved in the assessment process, the assessor should determine the order of the interviewing process. For example, it may be advisable to interview the young person in private, so as to maximize comfort and confidentiality. The interviewer may then want to meet also with the group as a whole, and with the family separately, if possible.

Involvement of Family and Others

The adolescent's family is an important factor in the adolescent's recovery. Therefore, it is critical to form a therapeutic alliance with the family to the fullest extent possible and to involve the family in the assessment process. In some cases, however, the family's direct involvement is not in the best interest of the child. For example, in the case of a family in which abuse is a serious issue, information should be collected from families; however, it would not be in the best interest of the child to include the abusers in the assessment process. (See chapter 4 for a discussion of confidentiality and release of information.)

In all cases, information about the family should be gathered. The ultimate goal of the assessment is the development and execution of a plan of corrective action that the family must accept and support.

The assessor should attempt to screen the family immediately after completing the assessment of the adolescent. The assessment should not be considered complete until

Assessor As Advocate

The person who leads the assessment process is responsible for:

- Developing a plan of corrective action.
- Developing a treatment plan of recommended interventions.
- Monitoring the implementation of the treatment plan.
- Establishing linkages with potential referral agencies and programs.
- Initiating and maintaining a communication system with other professionals responsible for some aspect of the young person's life.
- Seeing that the youth is properly transferred from assessment to the referrals or services she or he needs.
- Making or overseeing all the necessary arrangements for referral and other services.
- Foreseeing possible snags in the referral process and working to overcome them.

Note: The assessor is not a passive link in the chain from screening to treatment, but rather should be a broker who sees that needed services are arranged.

there has been time to assess the traditionally defined family and others identified by the court as legal custodians who can speak for the best interest of the adolescent, as well as the family that is defined by the young person. The assessor must determine who the "family" is as perceived by the adolescent and the legal entity in the assessor's jurisdiction (that is, the person or entity able to legally represent the interests of the adolescent).

The absence of a traditional family can be a barrier for adolescents seeking treatment. At-risk teens may be homeless or on the verge of homelessness. Some teens may go from shelter to shelter and have no address. In some States, if a child is a minor under the law, he or she will not be able to gain access to any services unless an adult signs for him or her. The assessor should be responsible for identifying and addressing this problem. Potential assistance may come in the form of emancipation for some adolescents, by working with the adolescent to make her or him a temporary ward of the State, or pursuing other such avenues.

The nature of the assessment itself will determine the point at which the family is assessed. Irrespective of the context of the assessment, the family should be assessed at the time of the assessment of the youth or immediately following it. There may be slight differences in timing for assessments for referral, treatment planning, or triage.

The assessment of an entire family requires a specific set of skills in addition to those needed to assess an individual. Such assessments require people who are highly skilled and trained, and able to interpret family dynamics, strengths, weaknesses, and social support systems. They must be able to deal with and interpret family dynamics. Assessors must also be able to consider cultural differences within the family, and to identify key family structures and interrelationship patterns in which the adolescent's AOD behavior is enmeshed. It is also essential to elicit previous treatment experiences, as well as previous attempts by the family to address the AOD problem.

It is also useful for the assessor to evaluate—through direct questioning—the family's feelings about the adolescent. Do the family's responses indicate the desire to help the adolescent, or do they suggest that the family sees the adolescent as "the problem?" These responses are useful in determining how to best proceed in working with the adolescent and the family. Key sources other than family members are school officials, court officials, social service workers (especially when the youth has been involved with the child welfare system), previous treatment providers, and previous assessors. Contacting these additional sources of information may be necessary to support or supplement the information that the adolescent provides in the comprehensive assessment.

Steps in the Multiple Assessment Approach

The multiple assessment approach includes interviews, observation, and specialized tests. Each of these steps is discussed below, as is the written report summarizing the assessment.

The Interview

More than anyone else, the adolescent knows his or her current

Family Involvement in Assessment And Development of a Treatment Plan

- Goal: to develop and execute an action plan that the family can accept and support.
- The family should be directly involved in assessment, to the fullest extent possible, whenever appropriate and in the best interest of the adolescent.
- The family should be interviewed right after the youth has been interviewed, if possible.
- Family assessment requires skill and training.
- The family's feelings about the young person should be assessed.

situation. A good interview can bring out much information about this situation. (Please refer to discussions above regarding involvement of the family in the interviewing process.)

The interview process should create a good therapeutic relationship between the adolescent and assessor (and when possible, the adolescent's family). The interview should be adapted to the age and culture of the adolescent. The examiner should quickly consider and be aware of the factors that might make this interview especially challenging.

For example, learning disabilities are one set of challenging factors that can have a significant impact on the interview and the way in which it is carried out. A youngster may have hearing problems or may have been labeled as a youth with "low intellectual functioning." (It is not unusual, however, for a troubled youth to be mistakenly labeled with one kind of problem, while perhaps more fundamental problems are unrecognized.) No matter what disability a young person may have, the interviewer should not "give up" on that youth, but administer the interview with awareness, understanding, skill, and an open mind.

In addition, a youngster's previous experience with this type of intervention can reduce the genuineness of the information provided. For instance, youngsters involved with the juvenile justice system may have been interviewed countless times by mental health, AOD abuse counselors, school counselors, lawyers, and the like. Such young people may have a keen knowledge of the operation of the justice system and know how to slant the information they provide to their best-perceived gains. Youth who have been involved with the child welfare system, possibly in and out of foster placements over the years, also may have been through countless numbers of interviews and may distrust the telling, yet again, of a complex life story.

Many factors can enhance the quality of information received during the interview. These factors include establishing rapport, using appropriate vocabulary as well as body language, formulating appropriate questions, and distinguishing between acceptance and approval of reported behavior.

There are standardized interviews available that have been developed by practitioners and researchers in the field that can enhance and formalize the interview process. In selecting a standardized interview instrument, the factors described in the introduction under the heading "Selection of Screening and Assessment Instruments" should be considered.

The following instruments fulfill many of the criteria for assessment instruments and are currently available. They are discussed in Appendix A.

- Adolescent Drug Abuse Diagnosis (A. Friedman, Philadelphia Psychiatric Center, Philadelphia, Pennsylvania)
- Adolescent Problem Severity Index (D. 24, H. Kushner, and A.T. McLellan, Biomedical Computer Research Institute, Philadelphia, Pennsylvania)
- CATOR (N. Hoffmann, University of Minnesota, St. Paul, Minnesota)
- Comprehensive Addiction Severity Index for Adolescents (K. Meyers, University of Pennsylvania, Philadelphia, Pennsylvania)
- Guided Rational Adolescent Substance Abuse Profile (Addiction Recovery Corporation, Waltham, Massachusetts)
- Prototype Screening/Triage Form for Juvenile Detention Centers (R. Dembo, University of South Florida, Tampa, Florida)
- Substance Abuse and Mental Health Assessment (Florida Department of Health and Rehabilitative Services, Tallahassee, Florida).

Observation

The assessor can supplement interview information through observation of the adolescent's voice, speech, or nonverbal

Observation

The assessor should supplement the information obtained through the structured interview with notes on the following, taking into account the adolescent's cultural and ethnic background:

- The youth's voice and speech
- The youth's nonverbal behavior
- Observation of family
- Views of other key informants
- The youth's pattern of responsibility
  - — At home
  - — In school
  - — At work
  - — Among peers.

behavior. Verbal and nonverbal cues can help to determine the adolescent's mood and general emotional state. Observation of the young person's family is extremely important and, as stated elsewhere, the family should be present at various points in the assessment process to the greatest extent possible.

In addition, examination of what the other key informants in the youngster's life have to say can aid in understanding the severity of the adolescent's problems. The adolescent's pattern of responsibility, problems with anger, and capacity to relate to others can frequently be established by reviewing other areas of a youngster's life.

For instance, do problems with responsible behavior and anger management occur in both home and school? In some cases, a youngster may often be late to class and produce homework irregularly because of job responsibilities. Aggressive behavior may be a problem at school but not at home, or vice versa. In any case, critical information and a more complete picture of the youngster's behavior can be derived through the collection of information observed in different settings of the youngster's life.

Specialized Testing

There are numerous specialized tests that can provide detailed information about the nature and severity of problems, as well as areas of strength, in the adolescent's life. In addition to an interview, one or more of a variety of standardized, normed tests may be administered that provide organized, detailed, and specific information about AOD abuse, mental health problems, learning deficits, social skills, and so on. Most of these tests require an experienced and trained administrator. Some tests further require confirmation of diagnosis by a licensed mental health or educational practitioner.

Some of the tests are self-administered—in other words, the youth completes the test him- or herself. These tests should be in the primary language of the adolescent and normed for the adolescent population. For example, if Spanish is the language that the youth uses at home, the test should be given in Spanish, with appropriate changes made in the words, phrases, and examples used, etc. (It should be noted, however, that tests often do not capture the many subtle cultural differences that exist in this society.) These and the other considerations should be taken into account when choosing such specialized instruments.

Some assessments should be referred to specialists. Obviously, the physical exam can be conducted only by or under the supervision of a physician. Mental disorder evaluations should be performed by a licensed mental health practitioner (structured testing can be done beforehand). Certain cognitive deficits may be recognized only by a trained and experienced specialist. The investigation of physical or sexual abuse requires a highly sensitive approach, and is best performed by individuals experienced in bringing out such information from adolescents.

NIDA has developed a screening instrument called the POSIT. The instruction manual for the POSIT includes a comprehensive assessment battery of specialized instruments for 10 "functional areas" of importance such as AOD use and abuse, physical health status, mental health status, family relations, and so on (see Appendix A). Specific recommendations are made concerning instruments that assess these various areas. This manual can provide an excellent beginning point of reference for the assessor who is looking for specific instruments to use in specialized areas.

Written Report

The complexity of adolescence requires that the individual being assessed is never reduced to a test score. Sattler (1988) addresses this issue effectively when he states that the assessment process "should never focus exclusively on a test score or a number. Each child has a range of competencies that can be evaluated by both quantitative and qualitative means." The aim is to assess the strengths and competence, as well as the limitations, of the child. After the information from the different sources has been assembled, the assessor writes a report of what he or she has learned about the adolescent in terms that can be understood by all concerned, including the adolescent. The written report becomes the vehicle to capture the adolescent's range of problems, strengths, and sources of support. The problems, strengths, and sources of support for the youth's family should be included as well.

To maintain continuity with previous workups and interventions, to make efficient use of all information available, and to spare the adolescent (and the party paying for the assessment) unnecessary duplication of effort, the assessor should be actively involved in determining if organized, accurate information on the adolescent already exists. When appropriate, that information should be integrated into the current written report. In particular, historical information can provide an indication of the progression of a set of symptoms and problem severity. However, the assessor's report, along with providing immediate direction for treatment and other interventions, has the potential to follow the young person for years and be a central factor in shaping decisions about the adolescent. Therefore, it is important not to include opinions and descriptions from previous reports unless that information is currently accurate. The report should deal with such issues as: (1) the way the adolescent processes information most effectively and how this will affect treatment; (2) "world view:" how the adolescent's past experiences

will affect his or her reaction to certain treatment interventions; (3) specific treatment placement recommendations and justifications; and (4) counselor recommendations. As the field has many different levels of professionals, it is important that these reports be written with specific treatment recommendations that can be understood by all.

The report should be distributed on a need-to-know basis to those service providers who will be working with the adolescent. Adolescents and their parents or guardians often request reports or assessment findings. One practice is to write the report to the parents of a youth under 18 years of age and directly to the young adult, if over 18, with a copy to the parents who may be paying for the assessment. However, in keeping with the requirements regarding confidentiality, information often cannot be released without the young person's approval and signature on the proper consent forms. Refer to chapter 4, "Legal Issues in the Screening and Assessment of Adolescents," for further elaboration on the laws regarding release of information.

The report should serve as a basis for linking youth with needed services. It should specify recommendations for treatment placement and post-treatment support services. The report should also contain a plan for use by a case manager or other responsible party for monitoring services provided to the youth.

The Written Report

The written report should identify:

- The severity of the AOD abuse
- Factors that contribute or relate to AOD abuse
- A corrective action plan to address problem areas
- A detailed plan to ensure that the treatment plan is
  - — Implemented and
  - — Monitored to its conclusion.

The written report should be careful to:

- Not reduce a youth to a test score
- Emphasize the youth's strengths as well as problems
- Capture the range of issues, strengths, and concerns
- Integrate previous workups when they indicate progression of symptoms and problems
- Not include opinions and descriptions from previous reports without thought and research—remember that the report can follow the youth for years.

The written report should be distributed:

- On a "need-to-know" basis only in accordance with Federal and State confidentiality rules
- Only with the signed approval of the adolescent (and, in some States, of the parent or guardian), as described in Federal or State laws.

The report should serve as a basis for linking youths with needed services.

- It should specify treatment placement recommendations.
- It should recommend post-treatment support services.

Note: The report should be written so that it can be understood by the youth and all parties concerned.

Chapter 4—Legal Issues in the Screening and Assessment of Adolescents[1]

Staff of alcohol and other drug (AOD) abuse treatment programs serving adolescents need to be aware of legal issues that affect program operation. Of top concern among these issues is confidentiality: the protection of the adolescent's right to privacy.

For example, staff of a program that assesses adolescents and tries to place them in appropriate treatment are often interested in seeking information from other sources, such as parents and schools, about the adolescents they screen. How can the program approach these sources and, at the same time, protect the adolescents' right to privacy? Can the program contact a parent or guardian without the adolescent's consent? If the adolescent tells program staff that he or she has been abused, can the program report it? If the adolescent is threatening harm to him- or herself or another, can the program call the authorities? Are there special rules regarding confidentiality for programs operating in the juvenile justice system or for child welfare programs?

This chapter will attempt to answer these questions. It has five sections. First, there is an overview of the Federal law protecting a youth's right to privacy when seeking or receiving AOD abuse treatment services. Next is a detailed discussion of the rules regarding the use of consent forms to get a youth's permission to release information about his or her seeking or receiving AOD services. The third reviews the rules for communicating with others about various issues concerning a youth who is involved with AOD abuse treatment services (including rules for communicating with parents, guardians, and other sources; reporting child abuse; warning others of an adolescent's threats to harm; and special rules for use within the juvenile justice system). The next section discusses other kinds of exceptions to the general rules—such as medical emergencies—that prevent the disclosure of information on youth involved with AOD abuse treatment services. The chapter ends with a few additional points concerning a youth's right to confidential services and the need for programs to obtain legal assistance.

Federal Law Protects Youth's Right to Privacy

Two Federal laws and a set of regulations guarantee the strict confidentiality of information about persons—including adolescents—receiving AOD abuse prevention and treatment services. The legal citations for these laws and regulations are 42 U.S.C. §§ 290dd-3 and ee-3 and 42 C.F.R. Part 2.

These laws and regulations are designed to protect clients' privacy rights in order to attract people into treatment. The regulations restrict communications more tightly in many instances than, for example, either the doctor-client or the attorney-client privilege. Violating the regulations is punishable by a fine of up to $500 for a first offense and up to $5,000 for each subsequent offense (§ 2.4).[2]

All At-Risk Youth Deserve Appropriate, Sensitive AOD Assessment

- Community groups and individuals must be able to screen and detect AOD problems.
- Youths have a right to assessment regarding issues in their lives related or leading to AOD abuse.
- Early identification should be followed by comprehensive assessment.
- Necessary linkages must be made within the community for additional assessment and treatment.

Some may view these Federal regulations governing communication about the adolescent and protecting clients' privacy rights as an irritation or a barrier to achieving program goals. However, most of the nettlesome problems that may crop up under the regulations can easily be avoided through planning ahead. Familiarity with the regulations' requirements will assist communication. It can also reduce confidentiality-related conflicts among the program, client, and an outside agency so that they occur only in a few relatively rare situations.

What Types of Programs Are Governed by the Regulations?

Any program that specializes, in whole or in part, in providing treatment, counseling, and/or assessment and referral services for adolescents with AOD problems must comply with the Federal confidentiality regulations (42 C.F.R. § 2.12(e)). Although the Federal regulations apply only to programs that receive Federal assistance, this includes indirect forms of Federal aid such as tax-exempt status or State or local government funding coming (in whole or in part) from the Federal Government.

Coverage under the Federal regulations does not depend on how a program labels its services. Calling itself a "prevention program" does not excuse a program from adhering to the confidentiality rules. It is the kind of services, not the label, that will determine whether the program must comply with the Federal law.

The General Rule: Overview of Federal Confidentiality Laws

The Federal confidentiality laws and regulations protect any information about an adolescent if the adolescent has applied for or received any AOD abuse-related treatment or referral services from a program that is covered under the laws. Services applied for or received can include assessment, diagnosis, individual counseling, group counseling, treatment, or referral for treatment.[3] The restrictions on disclosure (the act of making information known to another) apply to any information that would identify the adolescent as an AOD abuser either directly or by implication. The general rule applies from the time the adolescent makes an appointment. It also applies to former clients. The rule applies whether or not the person making an inquiry already has the information, has other ways of getting it, has some form of official status, is authorized by State law, or comes armed with a subpoena or search warrant.

Screening Should Be:

- ***Centered on the Adolescent!***
  Screening should not be driven by the screening instrument; the focus of screening should be to identify the intervention needs of the youth and his or her family.
- ***Holistic***
  Key aspects of the young person's life should be examined. This means that youth who are having problems in school, at home, on the job, etc., should be identified for AOD screening.

When May Confidential Information Be Shared With Others?

Information that is protected by the Federal confidentiality regulations may always be disclosed after the adolescent has signed a proper consent form. (As explained below, parental consent must also be obtained in some States.) The regulations also permit disclosure without the adolescent's consent in several situations, including medical emergencies, child abuse reports, program evaluations, and communications among staff.

The most commonly used exception to the general rules prohibiting disclosure is for a program to obtain the adolescent's consent. The regulations' requirements regarding consent are strict and somewhat unusual and must be carefully followed.

Consent: Rules About Adolescent Consent Forms To Disclose AOD Information

Most disclosures are permissible if an adolescent has signed a valid consent form that has not expired or been revoked (§ 2.31).[4]

A proper consent form must be in writing and must contain *each* of the items specified in § 2.31:

1. The name or general description of the program(s) making the disclosure;
2. The name or title of the individual or organization that will receive the disclosure;
3. The name of the client who is the subject of the disclosure;
4. The purpose or need for the disclosure;
5. How much and what kind of information will be disclosed;
6. A statement that the client may revoke (take back) the consent at any time, except to the extent that the program has already acted on it;
7. The date, event, or condition upon which the consent expires if not previously revoked;
8. The signature of the client (and, in some States, his or her parent); and

9. The date on which the consent is signed (§ 2.31(a)).

A general medical release form, or any consent form that does not contain all of the elements listed above, is not acceptable. (See sample consent form in Exhibit 3.) A number of items on this list deserve further explanation and are discussed under the bullets below: the purpose of the disclosure and how much and what kind of information will be disclosed, the youth's right to revoke the consent statement, expiration of the consent form, the adolescent's signature and parental consent, required notice against rereleasing information, and agency use of the consent form.

- ***The purpose of the disclosure and how much and what kind of information will be disclosed***

These two items are closely related. All disclosures, and especially those made pursuant to a consent form, must be limited to information that is necessary to accomplish the need or purpose for the disclosure (§ 2.13(a)). It would be improper to disclose everything in an adolescent's file if the recipient of the information needs only one specific piece of information.

In completing a consent form, it is important to determine the purpose or need for the communication of information. Once this has been identified, it is easier to determine how much and what kind of information will be disclosed, tailoring it to what is essential to accomplish the need or purpose that has been identified.

As an illustration, if an adolescent needs to have his or her participation in counseling verified in order to be excused from school early, the purpose of the disclosure would be "to verify treatment status so that the school will permit early release," and the amount and kind of information to be disclosed would be "time and dates of appointments." The disclosure would then be limited to a statement that "Susan Jones (the client) is receiving counseling at XYZ Program on Tuesday afternoons at 2 p.m."

Screening Considerations:

- Home and living situation of the youth
- Relationship of the youth to the child welfare system
- Relationship to the juvenile justice system
- Relationship to the school system and educational history
- Involvement with the mental health system
- Family history of AOD abuse or mental health problems
- Medical status
- Strengths or resiliency factors.

- ***Youth's right to revoke consent***

The adolescent may revoke consent at any time, and the consent form must include a statement to this effect. Revocation need not be in writing. If a program has already made a disclosure prior to the revocation, the program has acted in reliance on the consent—in other words, the program was relying on the consent form when it made the disclosure. Therefore, the program is not required to try to retrieve the information it has already disclosed.

The regulations state that "acting in reliance" includes the provision of services while relying on the consent form to permit disclosures to a third-party payer. (Third-party payers are health insurance companies, Medicaid, or any party that pays the bills other than the client's family or the treatment agency.) Thus, a program can bill the third-party payer for services provided before the consent was revoked. However, a program that continues to provide services after a client has revoked a consent authorizing disclosure to a third-party payer does so at its own financial risk.

- ***Expiration of consent form***

The form must also contain a date, event, or condition on which it will expire if not previously revoked. A consent must last "no longer than reasonably necessary to serve the purpose for which it is given" (§ 2.31(a)(9)). If the purpose of the disclosure can be expected to be accomplished in 5 or 10 days, it is better to fill in that amount of time rather than a longer period.

This is better than the practice of having all consent forms within an agency expire in 60 to 90 days. When uniform expiration dates are used, agencies can find themselves in a situation where there is a need for disclosure, but the client's consent form has expired. This means at the least that the client must come to the agency again to sign a consent form. At worst, the client has left or is unavailable, and the agency will not be able to make the disclosure.

The consent form does not have to contain a specific expiration date, but may instead specify an event or condition. For example, if an adolescent has been placed on probation at school on the condition that she or he attend counseling at the program, a consent form should be used that does not expire until the completion of the probation period. Or, if an adolescent is being referred to a specialist for a single appointment, the consent form should stipulate that consent will expire after he has seen "Dr. X."

- ***The signature of the adolescent (and the issue of parental consent)***

The adolescent must always sign the consent form in order for a program to release information even to his or her parent or guardian. The program must get the parent's signature in addition to the adolescent's signature only if the program is required by State law to obtain parental permission before providing treatment to the adolescent (§ 2.14). ("Parent" includes parent, guardian, or other person legally responsible for the minor.)

In other words, if State law does not require the program to get parental consent in order to provide services to the adolescent, then parental consent is not required to

Exhibit 3

Sample Consent Form

Consent for the Release of Confidential Information

I, _____, authorize XYZ Clinic to
(name of client or participant)

receive from/disclose to _____
(name of person and organization)

_____ for the purpose of _____
(need for disclosure)

the following information: _____.
(nature of the disclosure)

_____

I understand that my records are protected under the Federal and State Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it (e.g., probation, parole, etc.) and that in any event this consent expires automatically in 90 days unless otherwise specified below.

Other expiration specifications:

Date Executed _____

_____
Signature of client or participant

_____
Signature of witness

make disclosures (§ 2.14(b)). If State law requires parental consent to provide services to the adolescent, then parental consent is required to make any disclosures. The program must always obtain the adolescent's consent for disclosures, and cannot rely on the parent's signature alone.

There is one very limited exception to this rule, which is discussed in the section below, "Communicating with Parents or Guardians."

- *Required notice against redisclosing information*

Once the consent form has been properly completed, there remains one last formal requirement. Any disclosure made with written client consent must be accompanied by a written statement that the information disclosed is protected by Federal law and that the person receiving the information cannot make any further disclosure of such information unless permitted by the regulations (§ 2.32). This statement, not the consent form itself, should be delivered and explained to the recipient of the information at the time of disclosure or earlier.

The prohibition on redisclosure is clear and strict. Those who receive the notice are prohibited from rereleasing information except as permitted by the regulations. (Of course, an adolescent may sign a consent form authorizing such a redisclosure.)

- *Note on agency use of consent forms*

The fact that an adolescent has signed a proper consent form authorizing the release of information does not force a program to make the proposed disclosure, unless the program has also received a subpoena or court order (§§ 2.3(b)(1); 2.61(a)(b)). The program's only obligation is to refuse to honor a consent that is expired, deficient, or otherwise known to be revoked, false, or incorrect (§ 2.31(c)).

In most cases, the decision whether to make a disclosure pursuant to a consent form is up to the program to decide unless State law requires or prohibits disclosure once consent is given.

In general, it is best to follow this rule: disclose only what is necessary, for only as long as is necessary, keeping in mind the purpose for requesting the desired information.

Rules for Communicating With Others About Youth

Now that the rules regarding consent are clear, attention can turn to the questions that were introduced at the beginning of this chapter:

- How can programs seek information from collateral sources about adolescents they are screening?
- How can programs communicate with parents?
- Can programs report child abuse?
- Do programs have a duty to warn others of threats by adolescents, and if so, how do they communicate the warning?
- Are there special rules for adolescents who are involved in the juvenile justice system?

Seeking Information from Collateral Sources

Making inquiries of schools, doctors, and other health care providers might, at first glance, seem to pose no risk to an adolescent's right to confidentiality. But it does.

When a program that screens, assesses, or treats adolescents asks a school, doctor, or parent to verify information it has obtained from the adolescent, it is making a client-identifying disclosure that the adolescent has sought its services. In other words, when program staff seek information from other sources, they are letting these sources know that the youth has asked for AOD services. The Federal regulations generally prohibit this kind of disclosure unless the adolescent consents.

How then is a screening or assessment program to proceed? The easiest way is to get the adolescent's consent to contact the school, health care facility, etc.

Another method involves the program's asking the client to sign a consent form that permits it to make a disclosure for purposes of seeking information from collateral sources to any one of a number of entities or persons listed on the consent form. Note that this combination form must still include "the name or title of the individual or name of the organization" for each collateral source the program may contact. Whichever method the program chooses, it must use the consent form required by the regulations, not "a general medical release form."

Communicating with Parents or Guardians

As has been noted above, programs may not communicate with the parents of an adolescent unless they get the adolescent's written consent.

In getting the adolescent's consent, the program should discuss with the adolescent whether she or he (and the program) want the program to be able to confer with the adolescent's parents or guardians. Program staff should also talk to the youth about whether such discussions or meetings with the parent or guardian should occur just once or on a regular basis. This decision will affect how the program fills out the consent form.

If a program counselor and the adolescent jointly decide they want the counselor to confer with the parent or guardian only once, such as to obtain collateral information, the purpose of the disclosure (which must be stated on the consent form) would be "to obtain information from Mary's parents in order to assist in the screening (or assessment) process." The kind of information to be disclosed (which must also be stated on the consent

form) would be "Mary's application for services." The expiration date should be keyed to the date by which the counselor thinks screening or assessment will have been completed.

If the program and Mary decide they want the program's counselor to be free to talk to Mary's parents or guardians over a longer period of time, the program would fill out the consent form differently. The purpose of the disclosure would be "to provide periodic reports to Mary's parents" and the kind of information to be disclosed would be "Mary's progress in treatment." The expiration of this kind of open-ended consent form might be set at the date the program and Mary foresee her counseling ending or even "when Mary's participation in the program ends." (However, Mary can revoke the consent any time she wishes to.)

What if Mary refuses to consent? Since the Federal confidentiality regulations forbid disclosures without Mary's consent, the program cannot confer with her parents.

One special situation deserves mention. The Federal regulations contain an exception permitting a program director to communicate with a minor's parents when two conditions are met:

1. The program director believes that the adolescent, because of extreme AOD use or medical condition, does not have the capacity to decide rationally whether to consent to the notification of his or her guardians; and
2. The program director believes the disclosure is necessary to cope with a substantial threat to the life or well-being of the adolescent or someone else.

Thus, if an adolescent applies for services in a State where parental consent is required to provide services, but the adolescent applying for services refuses to consent to the program's notifying her parents or guardians, the regulations permit the program to contact a parent without an adolescent's consent only if those two conditions are met. Otherwise, the program must explain to the adolescent that while she has the right to refuse to consent to any communication with a parent, the program can provide no services without such communication and parental consent (§ 2.14(d)).[5]

Section 2.14(d) applies only to applicants for services. It does not apply to minors who are already clients. Thus, programs cannot contact parents of clients without consent even if the programs are concerned about the behavior of the children.

Reporting Child Abuse and Neglect

All 50 States and the District of Columbia have statutes requiring reporting when there is reasonable cause to believe or suspect child abuse or neglect. While many State statutes are similar, each has different rules about what kinds of conditions must be reported, who must report, and when and how reports must be made.

Most States now require not only physicians but also educators and social service workers to report child abuse. Most States require an immediate oral (spoken) report and many now have toll-free numbers to facilitate reporting. (Half of the States require that both oral and written reports be made.) All States extend immunity from prosecution to persons reporting child abuse and neglect. Most States provide penalties for failure to report.

Program staff will often need some form of training to review the State's child abuse and neglect laws and to clearly explain what the terms "abuse" and "neglect" really mean according to the law. A lay person's—or a professional's—idea of child neglect may differ greatly from the legal definition. For example, a child living with a parent involved in extensive AOD use, perhaps surrounded by a culture of drugs and alcohol, is often not considered to be "abused" or "neglected" unless certain legal conditions are met. Such legal definitions may go against the grain of what some staff members consider to be in the best interest of the child, but these are safeguards that have developed over time to protect the child, the parent, and the family unit.

Because of the variation in State law, programs should consult an attorney familiar with State law to ensure that their reporting practices are in compliance.[6] Since many State statutes require that staff report instances of abuse to administrators, who are then required to make an official report, programs should establish reporting protocols to bring suspected child abuse to the attention of program administrators. Administrators, in turn, should shoulder the responsibility to make the required reports.

The Federal confidentiality regulations permit programs to comply with State laws that require the reporting of child abuse and neglect. However, this exception to the general rule prohibiting disclosure of any information about a client applies only to initial reports of child abuse or neglect. Programs may not respond to follow-up requests for information or even to subpoenas for additional information, even if the records are sought for use in civil or criminal proceedings resulting from the program's initial report. The only situation in which a program may respond to requests for follow-up information is when the adolescent consents or the appropriate court issues an order under subpart E of the regulations.

Duty to Warn: Rules Concerning a Client's Threat to Commit A Crime

For most treatment professionals, the issue of reporting a client's threat to harm another or commit a crime is a troubling one. Many professionals believe that they have an ethical, professional, or moral obligation to prevent a crime when they are in a position to do so, particularly when the crime is a serious one.

There has been a developing trend in the law to require psychiatrists and other therapists to take "reasonable steps" to protect an intended victim when they learn that a client presents a "serious danger of violence to another." This trend started with the case of *Tarasoff v. Regents of the University of California*, 17 Cal.3d 425 (1976). In this case, the California Supreme Court held a psychologist liable for monetary damages because he failed to warn a potential victim that his client threatened to kill, and then did so. The court rules that if a psychologist knows that a client poses a serious risk of violence to a particular person, the psychologist has a duty "to warn the intended victim or others likely to apprise the victim of the danger, to notify the police, or to take whatever other steps are reasonably necessary under the circumstances."

While the *Tarasoff* ruling, strictly speaking, applies only in California, courts in a number of other States have followed *Tarasoff* in finding therapists liable for monetary damages when they failed to warn someone threatened by a client. Most of these cases are limited to situations where clients threaten a specific identifiable victim, and they do not usually apply where a client makes a general threat without identifying the intended target. States that have enacted laws on this question of a threat to a specific victim have similarly limited the duty to warn to such situations.

If an adolescent's counselor thinks the youth poses a serious risk of violence to someone, the counselor may well have a duty to warn either the potential victims or the police.

There is, however, another problem: the apparent conflict between the Federal confidentiality requirements and the *Tarasoff* case. The Federal confidentiality law and regulations prohibit the type of disclosure that *Tarasoff* and similar cases require, unless the disclosure is made pursuant to a court order or is made without identifying the individual who threatens to commit the crime as a client.[7] Moreover, the Federal regulations make it clear that Federal law overrides any State law that conflicts with the regulations (§ 2.20). In the only case, as of this writing, that addresses this conflict between Federal and State law (*Hansenie v. United States*, 541 F. Supp. 999 (D. Md. 1982)), the court ruled that the Federal confidentiality law prohibited any report.

Confronted with conflicting moral and legal obligations, what should an adolescent counselor do? A program that learns that an adolescent is threatening violence to a particular person or persons may be well advised to seek a court order permitting a report or to make a report without revealing client-identifying information. If a counselor believes there is a clear and imminent danger to a particular person, it is probably wiser to err on the side of making an effective report about the danger to the authorities or to the threatened individual. This is especially true in States that already follow the *Tarasoff* rule.

While each case presents different questions, it is doubtful that any prosecution (or successful civil lawsuit) under the confidentiality regulations would be brought against a counselor who warned about potential violence when she or he believed in good faith that there was real danger to a particular individual. On the other hand, a civil lawsuit for failure to warn may well result if the threat is actually carried out. In any event, the counselor should at least try to make the warning in a manner that does not identify the individual as an AOD abuser, as discussed below.[8]

"Duty to warn" issues represent another area in which staff training, as well as a staff review process, may be helpful. For example, a troubled youth may often engage in verbal threats as a way of "blowing off steam." Such threats may be the youth's cry for additional support services. Program training and discussions can assist staff in sorting out what should be done in each particular situation with specific youth.

Special Rules for Adolescents Involved in The Justice System: Rules for Consent Form And Disclosure of Information

Programs screening and assessing adolescents who are involved in the juvenile justice system (JJS) (for example, family court or juvenile court) must also follow the confidentiality rules that generally apply to AOD programs. However, some special rules apply when an adolescent comes for screening or assessment as an official condition of probation, sentence, dismissal of charges, release from detention, or other disposition of any criminal proceeding.

A consent form (or court order) is still required before any disclosure can be made about an adolescent who is the subject of JJS referral. However, the rules concerning the length of time that a consent is valid and the process for revoking the consent are different (§ 2.35). Specifically, the regulations require that the following factors be considered in determining how long the consent involving an adolescent who is the subject of a criminal

justice system referral will remain in effect:

- The anticipated duration of treatment,
- The type of criminal proceeding in which the juvenile is involved,
- The need for treatment information in dealing with the proceeding,
- When the final disposition will occur, and
- Anything else the client, program, or juvenile justice agency believes is relevant.

These rules allow programs to continue to use a traditional expiration condition for a consent form that once was the only one allowed—"when there is a substantial change in the client's justice system status." This formulation appears to work well. A substantial change in status occurs whenever the adolescent moves from one phase of the JJS to the next. For example, if an adolescent is on probation, there would be a change in JJS status when the probation ends, either by successful completion or revocation. Thus, the program could provide an assessment or periodic reports to the probation officer monitoring the adolescent, and could even testify at a probation revocation hearing if it so desired, since no change in criminal justice status would occur until after that hearing.

As for the revocability of the consent (the rules under which the youth can take back his or her consent), the regulations provide that the consent form can state that consent cannot be revoked until a certain specified date or condition occurs. The regulations permit the JJS consent form to be irrevocable so that an adolescent who has agreed to enter treatment in lieu of prosecution or punishment cannot then prevent the court probation department or other agency from monitoring his or her progress. Note that although a JJS consent may be made irrevocable for a specified period of time, its irrevocability must end no later than the final disposition of the criminal proceeding. Thereafter, the client may freely revoke consent.

Other Exceptions to The General Rule

Reference has been made to other exceptions to the general rule prohibiting disclosure regarding youth who are seeking or receiving AOD services.

In the pages that follow, seven additional kinds of exceptions to these Federal confidentiality rules are explained:

- Information that does not reveal the client as an AOD user,
- Information ordered by the court,
- Medical emergencies,
- Information regarding crimes on program premises or against program personnel,
- Information shared with an outside agency that provides service,
- Information discussed among people within the program, and
- Information disclosed to researchers, auditors and evaluators.

Communications that Do Not Disclose "Client-Identifying" Information

Federal regulations permit programs to disclose information about an adolescent if the program reveals no client-identifying information. "Client-identifying" information is information that identifies someone as an AOD abuser. Thus, a program may disclose information about an adolescent if that information does not identify him or her as an AOD user or support anyone else's identification of the adolescent as an AOD abuser.

There are two basic ways a program may make a disclosure that does not identify a client. The first way is obvious: A program can report aggregate data about its population (summing up information that gives an overview of the clients served in the program) or some portion of its populations. Thus, for example, a program could tell the newspaper that, in the last 6 months, it screened 43 adolescent clients—10 female and 33 male.

The second way is trickier: A program can communicate information about an adolescent in a way that does not reveal the adolescent's status as an AOD abuse client (§ 2.12(a)(i)). For example, a program that provides services to adolescents with other problems or illnesses as well as AOD abuse may disclose information about a particular client as long as the fact that the client has an AOD abuse problem is not revealed. An even more specific example: A program that is part of a general hospital could have a counselor call the police about a threat an adolescent made, so long as the counselor does not disclose that the adolescent has an AOD abuse problem or is a client of the AOD abuse treatment program.

Programs that provide only AOD services cannot disclose information that identifies a client under this exception, since letting someone know a counselor is calling from the "XYZ Treatment Program" will automatically identify the adolescent as someone in the program. However, a free-standing program can sometimes make "anonymous" disclosures, that is, disclosures that do not mention the name of the program or otherwise reveal the adolescent's status as an AOD abuser.

Court-Ordered Disclosures

A State or Federal court may issue an order that will permit a program to make a disclosure about an adolescent that would otherwise be forbidden. A court may issue one of these authorizing orders, however, only after it follows certain special procedures and makes particular determinations required by the regulations. *A subpoena, search warrant, or arrest warrant, even when signed by a judge, is not sufficient, standing alone, to require or even to permit a program to disclose*

information[9] (§ 2.61).

Before a court can issue a court order authorizing a disclosure about a youth that is otherwise forbidden, the program and any adolescents whose records are sought must be given notice of the application for the order and some opportunity to make an oral or written statement to the court.[10] Generally, the application and any court order must use fictitious (made-up) names for any known adolescent, *not* the real name of a particular youth. All court proceedings in connection with the application must remain confidential unless the adolescent requests otherwise (§§ 2.64(a), (b), 2.65, 2.66).

Before issuing an authorizing order, the court must find that there is "good cause" for the disclosure. A court can find "good cause" only if it determines that the public interest and the need for disclosure outweigh any negative effect that the disclosure will have on the client or the doctor-client or counselor-client relationship and the effectiveness of the program's treatment services. Before it may issue an order, the court must also find that other ways of obtaining the information are not available or would be ineffective (§ 2.64(d)).[11] The judge may examine the records before making a decision (§ 2.64(c)).

There are also limits on the scope of the disclosure that a court may authorize, even when it finds good cause. The disclosure must be limited to information essential to fulfill the purpose of the order, and it must be restricted to those persons who need the information for that purpose. The court should also take any other steps that are necessary to protect the adolescent's confidentiality, including sealing court records from public scrutiny (§ 2.64(e)).

The court may order disclosure of "confidential communications" by an adolescent to the program only if the disclosure:

- Is necessary to protect against a threat to life or of serious bodily injury, or
- Is necessary to investigate or prosecute an extremely serious crime (including child abuse), or
- Is in connection with a proceeding at which the adolescent has already presented evidence concerning confidential communications (for example, "I told my counselor . . . .") (§ 2.63).

Medical Emergencies

A program may make disclosures to public or private medical personnel "who have a need for information about [an adolescent] for the purpose of treating a condition which poses an immediate threat to the health" of the adolescent or any other individual. The regulations define "medical emergency" as a situation that poses an immediate threat to health and requires immediate medical intervention (§ 2.51).

The medical emergency exception permits disclosure only to medical personnel. This means that the exception cannot be used as the basis for a disclosure to the police or other nonmedical personnel, including parents.

Under this exception, however, a program could notify a private physician or school nurse about a suicidal adolescent so that medical intervention can be arranged. The physician or nurse could, in turn, notify the adolescent's parents, so long as no mention is made of the adolescent's alcohol or drug abuse problem. Whenever a disclosure is made to cope with a medical emergency, the program must document in the adolescent's records:

- The name and affiliation of the recipient of the information,
- The name of the individual making the disclosure,
- The date and time of the disclosure, and
- The nature of the emergency.

Crimes on Program Premises or Against Program Personnel

When an adolescent has committed or threatened to commit a crime on program premises or against program personnel, the regulations permit the program to report the crime to a law enforcement agency or to seek its assistance. In such a situation, without any special authorization, the program can disclose the circumstances of the incident, including the suspect's name, address, last known whereabouts, and status as a client at the program (§ 2.12(c)(5)).

Sharing Information with An Outside Agency that Provides Program Services ("QSOAs")

If a program routinely needs to share certain information with an outside agency that provides services to the program, it can enter into what is known as a qualified service organization agreement ("QSOA").

A QSOA is a written agreement between a program and a person providing services to the program, in which that person:

1. Acknowledges that in receiving, storing, processing, or otherwise dealing with any client records from the program, he or she is fully bound by [the Federal confidentiality] regulations; and
2. Promises that, if necessary, he or she will resist in judicial proceedings any efforts to obtain access to client records except as permitted by these regulations (§§ 2.11, 2.12(c)(4)).

A sample QSOA is provided in Exhibit 4.

A QSOA should be used only when an agency or official outside the program is providing a service to the program itself. An example is when laboratory analyses or data processing are performed for the

Exhibit 4

Qualified Service Organization Agreement

XYZ Service Center ("the Center") and the _____

_____

(Name of the Program)

("the Program") hereby enter into a qualified service organization agreement, whereby the Center agrees to provide _____

_____

(Nature of services to be provided)

_____

_____

Furthermore, the Center:

(1) acknowledges that in receiving, storing, processing, or otherwise dealing with any information from the Program about the clients in the Program, it is fully bound by the provisions of the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Client Records, 42 C.F.R. Part 2; and

(2) undertakes to resist in judicial proceedings any effort to obtain access to information pertaining to clients otherwise than as expressly provided for in the Federal Confidentiality Regulations, 42 C.F.R. Part 2.

Executed this ___ day of _____, 199_.

_____
President
XYZ Service Center
[address]

_____
Program Director
[Name of the Program]
[address]

program by an outside agency.

A QSOA is not a substitute for individual consent in other situations. Disclosures under a QSOA must be limited to information that is needed by others so that the program can function effectively. A QSOA may not be used between different programs providing AOD abuse treatment and other services.

Internal Program Communications

The Federal regulations permit some information to be disclosed to individuals within the same program:

> The restrictions on disclosure in these regulations do not apply to communications of information between or among personnel having a need for the information in connection with their duties that arise out of the provision of diagnosis, treatment, or referral for treatment of AOD abuse if the communications are (i) within a program or (ii) between a program and an entity that has direct administrative control over that program (§ 2.12(c)(3)).

In other words, staff who have access to client records because they work for or administratively direct the program—including full- or part-time employees and unpaid volunteers—may consult among themselves or otherwise share information if their substance abuse work so requires (§ 2.12(c)(3)).

A question that frequently arises is whether this exception allows a program that assesses or treats adolescents and that is part of a larger entity—such as a school—to share confidential information with others who are not part of the assessment or treatment unit itself. The answer to this question is among the most complicated in this area. In brief, there are circumstances under which the assessment unit can share information with other units. However, before such an internal communication system is set up within a large institution, it is essential that an expert in the area be consulted for assistance.

Research, Audit, or Evaluation

The confidentiality regulations also permit programs to disclose client-identifying information to researchers, auditors, and evaluators without client consent, providing certain safeguards are met (§§ 2.52, 2.53).[12]

Other Rules About Youths' Right to Confidentiality When Seeking or Receiving AOD Services

Client Notice and Access to Records

The Federal confidentiality regulations require programs to notify clients of their right to confidentiality and to give them a written summary of the regulations' requirements. The notice and summary should be handed to adolescents when they begin participating in the program or soon thereafter (§ 2.22(a)). The regulations contain a sample notice.

Programs can use their own judgment to decide when to permit adolescents to view or obtain copies of their records, unless State law allows clients or students the right of access to records. The Federal regulations do not require programs to obtain written consent from clients before permitting them to see their own records.

Security of Records

The Federal regulations require programs to keep written records in a secure room, a locked file cabinet, a safe, or other similar container.[13] The program should establish written procedures that regulate access to and use of adolescents' records. Either the program director or a single staff person should be designated to process inquiries and requests for information (§ 2.16).

A Final Note

AOD programs should try to find a lawyer familiar with local laws affecting their problems.

As has already been mentioned, State law governs many concerns relating to screening and assessing adolescents. A practicing lawyer with an expertise in adolescent AOD concerns is the best source for advice on such issues. Moreover, when it comes to certain issues, the law is still developing. For example, programs' "duty to warn" of clients' threats to harm others is constantly changing as courts in different States consider cases brought against a variety of different kinds of care providers. Programs trying to decide how to handle such a situation need up-to-the minute advice on their legal responsibilities.

Endnotes

1. This chapter was written for the consensus panel by Margaret K. Brooks, Esq., Montclair, New Jersey.

2. Citations in the form "§ 2..." refer to specific sections of 42 Code of Federal Regulations (C.F.R.) Part 2.

3. Only adolescents who have "applied for or received" services from a program are protected. If an adolescent has not yet been evaluated or counseled by a program and has not him- or herself sought help from the program, the program is free to discuss the adolescent's AOD problems with others. But, from the time the adolescent applies for services or the program first conducts an evaluation or begins to counsel the youth, the Federal regulations govern.

4. Note, however, that no information that is obtained from a program (even if the patient consents) may be used in a criminal investigation or prosecution of a patient unless a court order has been issued under the special circumstances set forth in § 2.65. 42 U.S.C. §§ 290dd-3(c), ee-3(c); 42 C.F.R. § 2.12(a),(d).

5. In States where parental consent is not required for treatment, the regulations permit a program to withhold services if the minor will not authorize a disclosure that the program needs in order to obtain financial reimbursement for that minor's treatment. The regulations add a warning, however, that such action might violate a State or local law. § 2.14(b).

6. If an attorney is not immediately available, and someone wants information about child abuse and neglect rules within a particular State, contact the social service or child welfare agency for that area. Nationally, the Child Welfare League of America (CWLA) can also be contacted at (202) 638-2952.

7. The court order exception and the exception for non-patient-identifying disclosures are discussed below.

8. For instance, a counselor employed by an AOD program that is part of a mental health facility could phone the police or the potential target of an attack, identify herself as "a counselor at the Cherry Valley Mental Health Clinic," and explain the risk to the potential target. This would convey the vital information without identifying the adolescent as an AOD abuser. Counselors at free-standing AOD units may make similar calls, but may not give the name of the program.

9. For an explanation about how to deal with subpoenas and search and arrest warrants, see *Confidentiality: A Guide to the Federal Laws and Regulations*, published in 1990 by the Legal Action Center, 153 Waverly Place, New York, NY 10014.

10. However, if the information is being sought to investigate or prosecute a patient for a crime, only the program need be notified (§ 2.65). And if the information is sought to investigate or prosecute the program, no prior notice at all is required (§ 2.66).

11. If the purpose of seeking the court order is to obtain authorization to disclose information in order to investigate or prosecute a patient for a crime, the court must also find that: (1) the crime involved is extremely serious, such as an act causing or threatening to cause death or serious injury; (2) the records sought are likely to contain information of significance to the investigation or prosecution; (3) there is no other practical way to obtain the information; and (4) the public interest in disclosure outweighs any actual or potential harm to the patient, the doctor-patient relationship, and the ability of the program to provide services to other patients. When law enforcement personnel seek the order, the court must also find that the program had an opportunity to be represented by independent counsel ("counsel" is an appointed lawyer). If the program is a governmental entity, it *must* be represented by counsel (§ 2.65(d)).

12. For a more complete explanation of the requirements of §§ 2.52 and 2.53, see *Confidentiality: A Guide to the Federal Laws and Regulations*, published in 1990 by the Legal Action Center, 153 Waverly Place, New York, NY 10014.

13. Staff in juvenile detention facilities, who work in institutions where resources are sometimes stretched to the limit, may experience problems with having access to equipment that can be locked. However, procedures must be worked out that follow the intention of the regulations as closely as possible.

Chapter 5—Screening and Assessment Of Adolescents in Juvenile Justice Settings

Overview

It is estimated that up to 250,000 adolescents who enter the juvenile justice system (JJS) in the United States each year have a diagnosable alcohol and other drug (AOD) disorder. The percentage of juveniles with AOD disorders, among groups of delinquents that were studied, ranged from 19 percent to 67 percent.

A growing body of literature indicates that adolescents entering the JJS have multiple problems in addition to AOD abuse, including:

- Physical or sexual abuse;
- Psychological and emotional problems;
- Poor performance in school;
- Family difficulties, which may include a history of AOD abuse, mental health problems, parental neglect, foster care placement, and involvement in criminal activity;
- Youth-related violence and involvement with drug sales;
- Living in neighborhoods where economic hardship, lack of employment opportunities, inadequate housing, and other factors related to poverty and low income have led to community-wide despair and hopelessness among adults as well as youth.

These interrelated problems have usually developed over several years, and may not have been detected during previous contacts of the youth with social service agency staff, school counselors, or law enforcement personnel. As a result, problems are often quite severe by the time an adolescent enters the JJS. The scope and severity of these psychosocial problems place juvenile offenders at significant risk for return to AOD use and for further delinquent behavior. The depth of the problems produces unique challenges for staff providing screening and assessment in the juvenile justice system.

Most adolescents for whom a delinquency petition is filed have had numerous prior contacts with law enforcement, probation, and the courts. A primary goal of AOD use screening and assessment among juvenile offenders is to prevent their further involvement in the JJS.

The JJS traditionally has maintained an episodic interest in these individuals, dealing with each problem separately. The JJS has typically focused on the behaviors and activities that the adolescent engaged in immediately before the youth's current involvement in the system, without examining the history of psychosocial problems contributing to AOD abuse and delinquent behavior. Individual monitoring of adolescents entering the juvenile justice system frequently ends at the completion of supervision. No further tracking is provided to make sure the adolescent receives services that might help to remedy key problem areas. Severe lack of funding for

Youth in Juvenile Justice Settings: Overview of Screening and Assessment

- Severe lack of funding in this area has a major impact on the assessment process.
- Assessment should be provided at earliest possible point.
  - Must be repeated at different stages (intake, pre- and postadjudication).
  - Must assess whole person, not just AOD abuse.
  - Is crucial for flagging potential emergency situations, such as suicide attempts.
- Depth of screening and assessment provided at any given point is influenced by:
  - Disposition of case (has the youth been committed or been conditionally released to home or youth shelter?) and
  - Likelihood of further involvement in the JJS.

adolescents has a big impact on the ability of systems and workers within these systems to give the comprehensive scope of service often needed.

Screening and assessment should be provided at the earliest possible point in the youth's contact with the JJS in order to identify adolescents who are at risk for further involvement in AOD abuse and serious delinquent behavior.

Multimodal, holistic assessment and treatment approaches are needed. In other words, different approaches can be taken, keeping in mind the whole picture of a young person's physical, emotional, and environmental circumstances. A single focus on the AOD abuse may fail to identify other critical problems that may contribute to future delinquent behavior.

Screening and assessment activities within the JJS must be repeated at different stages in the system (intake, preadjudication,[1] and postadjudication[2]), to detect changes over time in the pattern of AOD abuse, related problem behaviors, and the need for services. Screening and assessment—provided at different stages of the juvenile justice system—are particularly important in identifying adolescents at high risk for AOD abuse problems who have had frequent prior contact with the system, but who may not have participated in AOD abuse treatment or community services. Because it is difficult to transfer information gathered at earlier stages of the system, it is often necessary to repeat the screening and assessment when a juvenile is placed on probation or is committed to a juvenile facility or program.

The need for widespread screening and assessment for AOD abuse and related problems within the U.S. has been addressed by the National Commission on Correctional Health Care, in its *Standards for Health Services in Juvenile Detention and Confinement Facilities* (1992). In general, the depth of the screening or assessment provided at a given point in the JJS should be determined by: (1) the type of dispositional decision considered (e.g., conditional release or commitment), and (2) the likelihood of further involvement in the juvenile justice system. A high priority should be established for screening and assessment with adolescents who are unlikely to be referred further within the JJS, in order to identify immediate needs for community services outside the system.

Selection of Screening and Assessment Instruments

Selection of screening and assessment instruments for use with juveniles should be guided by several factors: (1) reliability and validity of the instrument, (2) the adolescent population(s) for which the instrument was normed and developed, (3) the type of settings in which the instrument was developed, and (4) the intended purpose of the instrument.

Important features[3] of good screening and assessment instruments include:

- High test-retest reliability: Are there similar results when the test is given again on the same youth at the same point in time—for instance, later that day or week?
- Strong correlation with other instruments attempting to measure the same construct (e.g., AOD abuse problem severity): Is there a strong relationship between the results obtained from this instrument and the results obtained from other instruments designed to look at the same kind of problem?
- Demonstrated ability to predict criterion measures (for example, school performance, performance in treatment, and substance abuse relapse): Has the test proven over time that it has helped to predict certain specific behaviors in young persons in the same or similar populations?
- Availability of normative data for age, gender, ethnic and cultural groups, and different types of populations and settings (for example, school, detention center, and residential substance abuse treatment program): Has research been done to show the extent to which this test or instrument has been used successfully among different populations of young people and in different kinds of settings?
- The ability to measure cognitive and behavioral changes over time: Has the test been able to measure changes in a young person's behavior as well as changes in his or her thinking, reasoning, and remembering?
- Ease of use;
- Expertise and training required to administer the test;
- Amount of time required to administer it;
- The extent to which the instrument takes the family into consideration as part of the assessment process;
- Possibility of bias, particularly cultural bias;
- Cost per interview;
- Motivation level and language skills required of the youth;
- Ability of the interviewer to detect "good faking" or random responses;
- Age-appropriateness of instrument;
- Credibility of the test with the professional community and with people who have a stake in the adolescent's case.

Materials accompanying screening and assessment instruments should describe the research that has been done to examine how reliable and valid these instruments have been and the settings in which the instruments are best used. The cost of instruments should be balanced against their potential usefulness in the juvenile justice setting.

A wide range of screening and assessment instruments is currently available and marketed to JJS agencies and facilities. The quality of these instruments varies greatly. Many of them feature computer-enhanced scoring or interpretation.

All instruments should be examined carefully. There should be a determination whether information regarding reliability and validity is available, and if it is presented in sufficient detail to judge the utility of instruments in juvenile justice settings.

Reliance on computerized interpretation of screening and assessment instruments should be avoided, particularly when critical items and the rules used to decide the interpretation of results are not fully described. Complex decisions regarding a juvenile's referral or need for treatment should not be based on results of test instruments alone; interviews, behavioral observation, or other sources of back-up information should be used to supplement test results. Reliance on a structured instrument, or a set of such instruments, may also limit the scope of information collected, and may not always be sensitive to the individual needs of the adolescent.

Screening and Assessment Protocols[4]

The following discussion reviews several different types of screening and assessment protocols implemented in juvenile justice settings. Information is provided regarding the purpose of the various types of screening and assessment, important domains (or content areas) to be probed, and instruments currently available for use in the juvenile justice system. These instruments are recommended with the warning that additional research is needed to determine the validity of screening and assessment instruments in juvenile justice settings.

Screening and Assessment At Key JJS Processing and Decision Points

Procedures need to be developed to ensure that the results of screening and assessment follow the adolescent through successive stages of the JJS. Exhibit 5 is a matrix that describes the purpose of each of five types of screening or assessment: preliminary screening, risk assessment, drug testing/urinalysis, psychosocial assessment, and comprehensive assessment. For each type, the matrix indicates the domains that the screening or assessment is designed to probe and notes which appendix describes available instruments.

Whenever possible, results of preadjudication screening and assessment should include a checklist or other means to identify a juvenile's relevant problem areas. Results should also define specific services needed and alternative types of services available in the community to assist judges, probation officers, and others working with the juvenile to develop a disposition plan. Screening and assessment instruments should be selected to assist in this process by readily identifying problem areas and levels of problem severity. Consultation should be provided to the juvenile court in interpreting results from various assessment protocols that are reviewed at the time of disposition.

It may be useful for juvenile justice and clinical staff from community social service agencies to collaborate in developing procedures for triage and referral. Staff from community agencies should be encouraged to "reach in" to detention and other secure facilities to assist in developing and implementing individualized aftercare plans for juvenile offenders. For example, community agency staff may be particularly useful in clarifying admission criteria for various community treatment programs. Community agency staff can also help to secure family involvement in aftercare services, and link juveniles to a range of other services. (Likewise, JJS staff should also be encouraged to "reach out" to facilitate adequate community involvement.)

Procedures need to be developed by juvenile justice agencies to guide referral decisions for AOD abuse assessment, mental health assessment, and other relevant community services. Decision rules guiding referrals for further assessment should include the development of threshold criteria (e.g., behavioral markers and test scores) for referral, and should reflect:

- The severity of the problem,
- The capabilities of community agencies to provide comprehensive assessment or related services, and
- Available resources for community assessment services.

In recognition of the importance of early detection and intervention, rules for deciding how to interpret the results of initial screening should be designed to be overinclusive in identifying adolescents who may have AOD abuse problems. In other words, it is better to identify more youth as having AOD abuse problems than to be overly cautious and miss some. Rules for deciding how to interpret the results of psychosocial assessment may be more conservative in consideration of scarce resources for providing further comprehensive assessment.

In some areas, screening and assessment units have been successfully implemented in detention centers to identify adolescents with AOD abuse and mental health problems. Many delinquents entering detention centers have not received prior AOD abuse or mental health screening or assessment, despite a history of frequent contact with the juvenile justice system. The detention setting offers an important opportunity to identify adolescents who are at high risk for further delinquent behavior

Exhibit 5
Types of Screening/Assessment

Initial Screening	Risk Assessment	Drug Testing/Urinalysis	Psychosocial Assessment	Comprehensive Assessment
Purposes				
To determine emergency needs with respect to supervision, medical, and psychological treatment.	To evaluate suicide potential, whether youth will be detained, level of custody/restrictiveness, likelihood of further delinquency or substance use, or degree of compliance with community supervision.	To determine the re-cent use of AOD for detection, monitor-ing, and supervision.	Refers to both psychological and social/environmental aspects of a youth's life.	To clarify factors related to onset of problems, described history and development of problems, assess problem severity, draw diagnostic/treatment implications.
Domains Probed				
(1) Acute intoxication/ withdrawal and need for detoxification, (2) suicide risk, (3) potential for violent behavior, or (4) other immediate medical or psychological needs.	(1) Demographic variables,(2) offense severity and evidence of AOD abuse; (3) delinquency history, severity of past offenses, disposition of prior charges, prior violations of supervision, escape/absconding, and past involvement in community diversion programs; (4) current legal status; (5) AOD abuse history; (6) psychological functioning and motivation, and (7) any mitigating or aggravating factors.	Alcohol, ampheta-mines, cocaine, can- nabinoids, opiates, PCP	(1) Demographic and personal history information, (2) AOD abuse history, (3) history of delinquent and aggressive behavior, (4) medical status, (5) psychological/emotional status, (6) family relationships, (7) peer relationships/social skills, (8) educational status, (9) vocational status (10) evidence of physical or sexual abuse, (11) specialized sub-stance abuse screening, and (12) detailed personal, family and peer history of involvement in the juvenile or adult justice systems.[1]	(1) AOD abuse history, diagnosis of dependence and dual disor-ders,[2] (2) delinquent and aggres-sive behavior, (3) medical status, (4) psychological and emotional status, (5) family relationships, (6) peer relationships and social skills, (7) educational status, (8) vocational status, (9) physical or sexual abuse, and (10) other markers of disturbed functioning (e.g., fire-setting, cruelty to animals).[3]
Appendix Describing Available Instruments				
Appendix A	Appendix A	Appendix B	Appendix A	Appendix A

[1] The following areas should be addressed within the specialized abuse screening protocol: (1) motivation to participate in treatment; (2) recognition of an AOD problem; (3) AOD history, including types and modes of substance abuse, quantity and frequency of use, and patterns of recent use; (4) HIV risk behaviors associated with AOD abuse; (5) current AOD problem severity and intensity, diagnosis of chemical dependency, and level of AOD treatment services required; (6) the association between AOD abuse and delinquent behavior (offenses committed while under the influence of alcohol or other drugs, and offenses committed to obtain alcohol or other drugs); (7) prior involvement in AOD abuse treatment, including the type and location of services, and responses to treatment.

[2] A diagnosis of dual disorders (also known as "dual diagnosis") refers to a situation in which a young person has been diagnosed as having a mental health problem in addition to AOD abuse.

[3] Other markers of disturbed functioning may include: (1) history of running away from home, and truancy; (2) evidence of stealing, property destruction, and breaking into others' homes; (3) physical cruelty to others, confrontation of crime victims, and use of weapons; (4) initiation of fights and forcible sexual activity with others; and (5) other cognitive and psychological markers (e.g., low frustration tolerance, low self-esteem, irritability, poor modulation of or ability to handle anger).

and AOD abuse. Resources permitting, the period of juvenile detention can be used constructively to provide initial screening, risk assessment, psychosocial assessment, or more comprehensive assessment.

Preliminary steps in developing a screening and assessment unit within detention centers include meetings with community agencies to review the goals of the unit and an updated review of available referral services. Community service providers can also be invited to visit the detention facility. Preliminary meetings with external agencies can be designed to develop a community referral network for AOD-involved juveniles. In addition, negotiations may need to take place within various levels of the bureaucracies that oversee the detention center to persuade authorities that an AOD screening and assessment unit is needed, perhaps entailing the allocation of additional resources. (This "lobbying" may be formal or informal in nature, to include meetings and reports documenting the need.) Community service providers may be enlisted to support such efforts as well.

Centralized intake and referral units in the community provide an alternative to specialized screening and assessment units developed in detention centers as a setting for early identification of "high risk" adolescents in the JJS. Within a centralized intake unit, comprehensive information is compiled regarding the adolescent's mental health, substance abuse, medical, educational, and other social service needs. Centralized intake units rely on collaboration among law enforcement and social service agencies to conduct evaluations of youth and to make referrals for community services.

Implementation of Screening and Assessment Protocols

All juveniles entering a juvenile justice facility should receive an initial screening, risk assessment, and follow-up assessment, as indicated. Initial screening should be conducted within 24 hours of entry to the agency or facility. Screening and assessment activities may need to be completed over the course of several days for juveniles who are intoxicated, show symptoms of mental illness, are experiencing significant stress related to arrest or incarceration, or are not honestly disclosing information during an initial interview. Self-administered instruments (instruments that the youth fills out in writing) should be designed to reflect the reading level and cultural background of the juvenile population. Alternative screening and assessment measures should be developed to accommodate the needs of juveniles with limited reading skills and with physical disabilities.

Data need to be collected from different sources (including biological specimens to test for drug use—see Appendix B for further discussion) whenever possible, to supplement self-report information obtained from a juvenile at the time of screening or assessment. Attempts should be made to gather collateral or supporting data from family members, police, social workers, school counselors, or other individuals who may be familiar with the juvenile, or with the most recent offense.

Juvenile Justice Settings: Screening and Assessment Protocols Are Needed

Protocols should be developed with the following points in mind:

- Develop protocols to ensure that the results of screening and assessment follow the youth through successive stages of JJS involvement.
- Results of preadjudication screening should include a checklist to:
  - Highlight problems
  - Define needed services
  - State which of these services are available in the community.
- Screening results should help judges, probation officers, and others to develop a disposition plan.
- Consultation to juvenile court should be provided to interpret results.
- Collaboration is needed for triage and referral procedures among:
  - Courts
  - JJS staff
  - Social service staff.

Results of screening and assessment should describe the various sources of the information obtained, and, whenever possible, should indicate how the different sources of information contributed to findings and recommendations. The use of screening and assessment instruments should be supplemented by individual interviews. Individual interviews are particularly important in clarifying responses and gathering additional information related to suicidal behavior, recent substance abuse, and mental health symptoms. Screening and assessment activities should be conducted in a private room. An effort should be made to make sure the youngster feels safe and comfortable in the interview. The use of holding cells to conduct screening and assessment is *not* recommended.

In recording events leading up to the most recent offense, staff conducting screening and assessment interviews should describe information regarding the social context of delinquent behavior, including AOD abuse, peer involvement, and relevant psychosocial stressors. Similarly, the juvenile's perceptions of reasons for initiating and continuing to use AODs should be elicited.

Interviews should also be designed to evaluate the juvenile's perceptions and attitudes regarding: (1) the screening or assessment process, (2) the interviewer, (3) the juvenile justice setting in which the interview is conducted, and (4) the accuracy of information provided by the youth or by the interviewer regarding the youth.

The interviewer should evaluate the adolescent's reading level (if necessary) and other factors that may influence the quality of screening and assessment results (for example, effects of immediate intoxication, mental health symptoms, and motivation).

Juvenile justice staffing patterns should be developed to reflect the flow of referrals for screening or assessment. Assignment of juvenile justice staff exclusively to screening and assessment activities encourages burnout, and tends to restrict the diversity of the work experience and involvement in other aspects of the juvenile justice program. Juvenile justice staff are also frequently overburdened with large numbers of daily screenings and assessments. This burden may reduce the quality of information obtained and prevent identification of:

- Suicide risk,
- History of physical or sexual abuse, and
- The need for AOD abuse services.

Where resources are available, consideration should be given to contracting out screening and assessment services to community-based organizations.

Evaluation and Quality Assurance Monitoring

Screening and assessment often provide an important contribution to program evaluation activities. For example, this information is useful in describing characteristics of juvenile populations served at various stages of the system,

Juvenile Justice Protocols To Implement Screening and Assessment

- Initial screening should be done within 24 hours of entry.
- Full assessment should be done within several days of entry.
- Use of holding cells for screening and assessment is not recommended.
- Screening and assessment should follow many of the same guidelines used for youth in the community, such as:
  - The collection of data from different sources
  - The careful selection of the instrument used.
- The setting in which the interview is conducted is especially important in JJS settings and should be clearly noted in the written record.
- Juvenile justice staff should not be exclusively assigned to screening and assessment, as it encourages burnout!
- Suicide Risk—despite overburdened staff and large numbers of screenings and assessments, protocols must be implemented to flag potential suicides.
- Protocols are needed to guide JJS staff in responding to critical problems that may arise during screening and assessment, such as:
  - Reported physical or sexual abuse
  - Suicide threats
  - Violent or aggressive behavior
  - HIV-related concerns
  - Symptoms of withdrawal or acute intoxication.
- Quality assurance monitoring of screening and assessment records should be completed at regular intervals.
- Staff must receive adequate training in a number of key areas.

emerging trends in drug use, HIV risk behaviors, and physical or sexual abuse. The information may assist in:

- Documenting the need for additional community services for juvenile offenders;
- Identifying existing screening and assessment instruments that need modification;
- Evaluating changes over time in mental health status, substance abuse, or other areas of functioning;
- Identifying signals or situations that can help to predict disciplinary incidents within juvenile facilities or trigger relapse or recidivism following release from juvenile custody; and
- Supporting the need for ongoing screening and assessment activities within juvenile settings.

Screening and assessment information may also contribute to reports developed for facility or agency administrators describing patterns of juvenile admissions, severity of substance abuse or other problems, and service needs.

Quality Assurance:

Quality assurance should include:

- Periodic examination of records for accuracy and comprehensiveness
- Methods used to obtain information on youth
- Staff responses to critical issues identified
- Observation of interviews
- Debriefing following interviews
- Use of nonagency staff.

Screening and assessment instruments should include various measures of the severity of AOD abuse and other problems. Use of norm-referenced tests (tests where the normal range of responses for youth in various settings has been identified) are also useful in assisting evaluation efforts. Screening and assessment should be designed to provide an easily interpretable visual display of results, including problem severity ratings, scale scores, risk markers, or other measures. Instructional manuals and materials should accompany screening and assessment instruments to describe procedures for administration, scoring, and interpretation of results. Staff training or credentials needed for administration of screening and assessment instruments should be identified.

All juvenile justice facilities and programs need to develop policies and procedures for responding to critical issues that may arise during a screening or assessment interview. These issues include reported physical or sexual abuse, suicide threats, issues related to HIV status, aggressive behavior, and symptoms of acute intoxication or withdrawal. Staff should be trained in methods of responding to these issues and in documenting responses.

Quality assurance monitoring of screening and assessment records should be completed at regular intervals within all juvenile justice

Staff Training

Juvenile justice staff should receive training in the following areas:

- Legal and ethical issues (see list)
- Instrument administration
- Scoring and interpretation of instrument results
- Interviewing techniques
- Counseling techniques
- Management of critical incidents
- Implementing screening and assessment policies and procedures
- Observation of other interviews
- Cause and symptoms of stress and impact of stress on test results
- Potential for overestimating need for intensive services based on one interview
- HIV issues and adolescence; need for agency protocols.

agencies and facilities. Quality assurance activities should include examination of the accuracy and comprehensiveness of screening and assessment records, methods used to obtain information, staff responses to critical issues identified during screening and assessment, and the use of screening and assessment information in developing referral decisions.

Whenever possible, quality assurance activities should include observation of screening and assessment interviews and debriefing following interviews. Use of nonagency staff in quality assurance monitoring can often improve the objectivity of results. (People who work together may find it difficult to evaluate each other.)

Staff Training

All juvenile justice staff providing screening or assessment services should have received training in the following areas: cultural sensitivity and competence, legal and ethical issues, instrument administration, scoring and interpretation of instrument results, determination of reading abilities, interviewing techniques, report writing, interpersonal communication, counseling techniques, and management of critical incidents. Staff should also receive training in implementing policies and procedures related to screening and assessment. Juvenile justice staff assigned to administer screening and assessment protocols should observe interviews conducted by other staff, and should have regular opportunities to debrief following difficult screenings or assessment interviews and to discuss problems encountered in the use of various test instruments.

Staff conducting screening or assessment at intake to the juvenile justice system should be trained to recognize causes and symptoms of stress, and to develop an awareness of the potential impact of stress on test and interview results. Staff should also be alerted to the potential for overestimating the need for intensive treatment services based on results of an initial interview without the addition of collateral supporting information. Program procedures and training efforts should be designed to encourage staff to postpone more comprehensive screening or assessment if evidence of significant stress or acute intoxication or withdrawal is observed. Staff should also receive training on issues surrounding adolescents in juvenile justice facilities and HIV infection.

Juvenile justice staff should receive training in maintaining the confidentiality of screening and assessment information and in guidelines for reporting information. All staff involved in screening and assessment should understand the issues related to informed consent, mandatory reporting of child abuse or neglect, limits of confidentiality, and transfer of information to parents or guardians, courts, attorneys, or other agencies, and should be able to communicate this information to juveniles. Staff should also receive training in issues related to the duty to warn, in order to effectively respond to situations involving a juvenile's threat to commit a crime or to harm a potential victim.

Legal Issues

All juvenile justice organizations should develop policies and procedures regarding disclosure of confidential information, limits of confidentiality, informed consent, and the duty to warn potential victims of threats of violence. Procedures should be developed for communicating confidential information to the court and to external community agencies that may conduct assessment and treatment. Confidentiality requirements should be printed on screening or assessment instruments used in the juvenile justice system and in instructional materials accompanying these instruments. Information regarding access to AOD abuse, mental health and other services should be routinely communicated to adolescents upon their admission to a juvenile facility. Policies and procedures are also needed in regard to a number of HIV-related concerns within juvenile justice facilities. See chapter 4 for a more extensive review of legal issues pertaining to screening and assessment of AOD use.

Ethical and Legal Issues

Juvenile justice settings should develop policies and procedures with regard to the ethical and legal issues surrounding comprehensive screening and assessment in the following areas:

- Maintaining privacy during the interview process
- Disclosure of confidential information to
  - — Courts
  - — Community agencies
  - — Legal guardians
  - — Others
- Limits of confidentiality
- Informed consent issues
- HIV-related issues
- Mandatory reporting of child abuse or neglect
- Duty to warn potential victims of threats and violence
- Staff training, both initial and ongoing.

NOTE: Confidentiality requirements should be printed on all screening and assessment instruments and on all instructional materials. See chapter 4 (in particular the section on "court ordered disclosure") for further discussion of confidentiality.

Endnotes

1. Adjudication has to do with the decision or action taken by the court in a particular case. Preadjudication is the period before the court has taken action, when the youth is often detained, waiting for sentencing.
2. Post adjudication is the period after the courts have ruled on a case and the youth is given a specific disposition.
3. On the basis of comments from a number of reviewers who wish to use this document as a stand alone instrument, the discussion of selection of instruments presented in chapter 1 is offered here as well.
4. Protocols: As mentioned in earlier chapters, protocols are plans, including standards and procedures, used by service providers to carry out treatment.

Appendix A—Screening Instruments

*The complete NIDA manual includes information on reliability and validity. In addition, the instruction manual for each protocol reviews the instrument's reliability and validity.

Part I
Description and Review Of Screening Assessment Instruments For Alcohol or Other Drug-Abusing Adolescents Reviewed by NIDA

The National Institute on Drug Abuse (NIDA) has made this document available to the Center for Substance Abuse Treatment for inclusion in this Treatment Improvement Protocol as an appendix. It is taken from a NIDA manual entitled *Assessment Instruments for Drug Abusing Adolescents and Adults*. This is an abridged and slightly amended version of the NIDA manual, which includes information about assessment instruments for both adolescents and adults.

Introduction

Assessment is essential in identifying alcohol and other drug (AOD) abuse and related problems and formulating a suitable treatment plan for the AOD-abusing adolescent. The use of well-designed assessment instruments can enable us to gain an accurate, realistic understanding of the individual and the problems that he/she is experiencing. The information derived can also provide important insights into the young person's motivation and readiness to make use of and benefit from treatment.

In this Appendix, recommended instruments are listed and described. The presentation offers basic guidelines on effective use of these diagnostic instruments and procedures. Fundamental information is provided about each instrument: purpose, content, administration, time required for completion, training needed by the assessor, how the instrument can be obtained, its cost, and persons to contact for further guidance.

Some important criteria that have been used in the selection of these instruments are listed below.

1. The instrument must yield useful information for assessing and diagnosing the client's problems, for planning treatment, for tracking the progress of the client during treatment, and for followup evaluation of the client's status after treatment.

2. The instrument develops information that is quantifiable, thus providing scores that make comparison between repeated performances on the test and between subjects relatively easy. Such scores also facilitate statistical analyses of the performance of groups of individuals.

3. The instrument is relatively easy to administer and not excessive in length. It also provides reliable, valid, and meaningful assessments of these client characteristics, behavior, etc., which it is intended to measure.

4. The language and wording of the items are appropriate for the target population, and are acceptable to, and respectful of, the clients.

5. The instrument is sufficiently sensitive to the relevant types of client problems so as to reflect clinically meaningful changes made by the client.

6. The cost of the materials required for utilizing the instrument is not excessive.

Apart from these practical considerations, two other qualities were considered particularly important in the evaluation of measurement instruments: reliability and validity.

Reliability refers to the confidence that one can have in the consistency of the test item responses. Two types of consistency are involved: internal and repeated measurement. Internal consistency represents the expectation that the client's responses to various items do not contradict each other. For example, if the response to one question is that drugs are used "daily," it would be inconsistent for the client to say, in response to another question, that he or she rarely uses drugs (for example, "once per month").

The second type of reliability—based on performing repeated use of the measurement instrument and known as "test-retest"—refers to the expectation that the person's responses are pretty much the same over a short time period; that is, from day to day or even from week to week. Thus, if the instrument is administered a second time to the individual shortly after the initial administration, the results for the two occasions should be quite consistent with each other if the instrument has "test-retest" or repeated measurement reliability.

Validity refers to the extent or degree to which the assessment instrument measures what it is intended to measure. When a test is found to have little or no reliability, it cannot be expected to be valid, since the results are inconsistent and not dependable. Good reliability, however, does not guarantee validity. There are at least two or three kinds of validity normally mentioned in descriptions of assessment instruments.

One is referred to as "face validity." This means that, based on logical reasoning, the contents of the test are judged to be valid (that is, they deal with information, questions, or problems related to the stated objectives of the test). Thus, a high correlation between the ratings given to the test by several judges who are experienced with the characteristics or behavior the instrument reportedly measures would help to establish an instrument's "face validity."

Still another type of approach to establishing validity involves the use of two instruments—the one being developed and another that has already established reliability and validity and is also reported to measure the same behaviors or factors as the instrument being developed. Both are administered to the same group of subjects. Using statistical methods, one then determines the extent to which the results obtained from the two instruments converge (that is, they are consistent). This is referred to as "external validity."

For example, the Wechsler Adult Intelligence Scale has been demonstrated to be effective in assessing the thinking, memory, and learning capabilities of adults, and has established validity as a test of intelligence. If another instrument, such as one that requires a person to solve linguistic and graphic puzzles, were administered to the same group of individuals who were tested with the Wechsler Scale, this new test would be considered as also reflecting intelligence if the scores achieved by each individual were at about the same levels on both tests. These two sets of scores would be highly related to one another. It may be concluded that the new test also measures intelligence. It concurs with the validity already established by the Wechsler Adult Intelligence Scale.

A more complex but important type of validity is construct validity. This refers to whether the results derived from a test are consistent with and reflect the underlying theoretical notion it is expected to measure. It can be determined by assessing the extent to which the results obtained are in line with what the theory claims. For example, the developer of an assessment instrument may theorize that people who are likely to commit crimes are without clear-cut values of honesty, social conformity, or sympathy for other people, and are not thoughtful about their actions. A schedule or questionnaire is then organized containing items related to these traits. The questionnaire is administered to a group of known criminals and to a group known not to be criminals. When the questionnaires are scored, construct validity is present if the criminals and noncriminals are successfully distinguished from each other to a statistically significant degree.

Related to this is the issue of "predictive validity." This deals with the effectiveness with which an assessment instrument predicts how people will function or behave in the future. Thus, the criminality instrument mentioned above could be used on a group of people to predict whether they will actually become criminals. In this regard, they would be followed for several years after completing the questionnaire, and checked for evidence of criminality. The instrument would be considered to have predictive validity if a high correlation (for example, a correlation of .50 or higher) was determined between the results on the instrument and the later incidence of illegal behavior.

As is the case with reliability, validity evidence is reported in the form of correlations. Generally, validity coefficients tend to be much lower than reliability coefficients. They may range between .30 and .80 or even higher, depending on how closely related the test is to the criterion with which it is being compared, and the complexity of what is being evaluated by the test. Usually, when the complexity is great, as in the assessment of personality makeup, the validity coefficients are likely to be low. When, on the other hand, the complexity is not great, as in the assessment of simple mechanical skills, the validity coefficients are expected to be high. The user of the instrument should examine the data available on validity to determine whether it represents the type of validity that fits the purposes for which the test is to be used.

Norms, which are provided by the author of an assessment instrument, represent the scores or results that the types of people who are to be assessed by the instrument tend to obtain. No psychological instrument is validly useful for all people. Therefore, the author of the instrument is expected to report the types of individuals with whom its use is appropriate. This report should refer to such client characteristics as the age, sex, ethnicity, educational achievement, socioeconomic level, medical, and psychological status of the population on which the original measurements were made.

Norms are often provided as tables that show how the scores are distributed for key characteristics, such as the sex or age of the population. The central tendency, or the average, of the scores is shown, along with the range from highest to lowest scores. These normative tables can be very useful to the counselor in determining the extent to which a client's functioning is within normal or abnormal limits. Often, as a test is used more extensively, norms are expanded, and the instrument becomes appropriate for increasingly larger and differing types of client populations.

Conditions for administration of any test or assessment instrument should be clearly spelled out in a manual prepared by the author of the instrument to serve as a guide to the user. The manual for the instrument should describe how the test was constructed, and report available information on its reliability, validity, and norms. It should also describe the content and structure of the instrument, as well as how it relates to similar instruments.

Of great importance to the user is the author's description of how the instrument is to be administered, scored, and interpreted. Specific statements should include: 1) the purposes or aims the test can serve, 2) for whom the test is appropriate and for whom it is not appropriate, 3) whether the test can be administered in a group or only on an individual basis, 4) whether it can be self-administered or if it must be given by an examiner, 5) whether training is required for the assessor, and, if so, what kind, how much, how, and where it can be obtained, and 6) where the test can be obtained and what it costs.

Consideration of the above practical issues and of the conditions for administration should enable program staff to select the instruments that are most applicable and useful for their program and clients. Once selected, the tests should be administered in the manner recommended by the authors; no substitutions should be made for any test items, and no items should be eliminated or modified.

If this rule is not followed, the results obtained from the test cannot legitimately be interpreted in terms of the norms provided in the test manual. Changing the test in any way makes it, in effect, a different test, so that the reliability, validity, and norms reported for the test no longer apply, thus making it difficult to know how to interpret the results.

In some cases, there may be a need for a more in-depth and more definitive diagnostic assessment of some aspect(s) of a client's behavior, functioning, status, etc., than can be provided by any of the screening or assessment instruments recommended in this brochure. For example, for substance-abusing clients who have serious psychological, psychiatric, or emotional problems (usually referred to as being "dually diagnosed," or as having a comorbid condition), a broad screening instrument is not sufficient for establishing a definitive DSM-III-R mental illness diagnosis. A structured psychiatric interview, such as *The Revised Diagnostic Interview for Adolescents (DICA-R-A)* is indicated for this purpose. Such procedures normally would be carried out at a mental health or psychiatric clinic to which the client should be referred.

When screening clients for mental health issues is appropriate, on the other hand, specific instruments can be used. The results would then be useful in determining whether a more formal or extensive mental health assessment or referral for such services is warranted. For this type of screening, a structured psychopathological scale, such as the *Symptom Checklist-90 R (SCL-90R)* or the *Brief Symptom Inventory (BSI)*, may be useful. These are standardized methods for measuring the severity of nine dimensions of mental illness symptomatology (for example, anxiety, depression, and psychosis).

These types of instruments require less than 30 minutes to administer and provide fairly specific information about the type and severity of an individual's mental health problems. They are not, however, adequate as a substitute for a formal mental illness diagnosis or for the complete psychiatric status and psychiatric history obtained by means of a structured psychiatric interview.

Adolescent Drug Abuse Diagnosis (ADAD)

Introduction

The Adolescent Drug Abuse Diagnosis (ADAD) is a 150-item instrument for structured interview administration which produces a comprehensive evaluation of the client, and provides 10-point severity ratings for each of nine life problem areas. Composite scores to measure client behavioral change in each problem area during and after treatment can be calculated. This instrument is modeled on the Addiction Severity Index (ASI), which is used for adult clients.

Developer

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Purpose

- To assess substance abuse and other life problems
- To assist in treatment planning
- To assess changes in problem areas and severity over time.

Type of Assessment

Structured interview (with a format adopted from the ASI).

Life Areas Assessed

1. Medical
2. School
3. Employment
4. Social Relations
5. Family and Background Relationships
6. Psychological
7. Legal
8. Alcohol Use
9. Drug Use

Reading Level

Not applicable. The assessor interviews the client.

Credentials/Training

A 1-day training session is recommended. As an alternate minimal training method, a training videotape is available at a cost of $20.00. Technical assistance in the use of the training procedure is available by telephone.

Completion Time

45 minutes.

Scoring Procedures

Each life area is scored for problem severity on a 10-point scale. Mathematically derived composite scores (based on a formula for weighing selected item scores) can be used to assess changes in problem severity over time. These scores are independent of the interviewer's clinical judgment of the severity of each problem area.

Scoring Time

Less than 10 minutes

General Commentary

Contains both alcohol and other drug-related items. Measures: 1) the degree to which the client has been "troubled" by each type of problem; 2) the interviewer's ratings of the client's need for treatment for each problem area; 3) the degree of the client's desire and motivation for treatment; and 4) the degree of the client's denial or misrepresentation of his or her situation and behavior.

There is a shorter form (83 items) of the ADAD for followup tracking and evaluation of clients after treatment and for the evaluation of treatment outcome based on the composite scores.

Access

From developers (see above for address). The ADAD is in the public domain.

Pricing Information

A copy of the ADAD instrument will be mailed on request without charge, and with permission to make copies. The Instruction Manual is available for $10.00.

Friendly User

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Personal Experience Inventory (PEI)

Introduction

This is a comprehensive assessment instrument consisting of two parts, the Chemical Involvement Problem Severity (CIPS) Section, and the Psychosocial Section (PS). It provides a list of critical items that suggests areas in need of immediate attention by the treatment provider and summarizes problems relevant for planning the treatment indicators. It has "validity scales" to control for faking to appear good or bad. The CIPS section of the PEI provides for comprehensive coverage of alcohol and drug use and abuse and related problems.

The CIPS section does not provide the basis for establishing a diagnosis of a DSM-III-R substance abuse disorder. But the Adolescent Diagnostic Interview (ADI), which is available with the PEI, is a structured interview designed to assess DSM-III-R criteria for substance abuse disorder diagnoses (either for "alcohol abuse" or "alcohol dependency" or "drug abuse" or "drug dependency"). It also determines level of functioning, taking into account involvement with peers, opposite sex relationships, school behavior and performance, home behavior, and severity of psychosocial stressors. The ADI also screens for other mental disorders, including depression, mania, eating disorders, delusional thinking, hallucinations, attention deficit disorder, anxiety disorder, and conduct disorders, as well as screening for memory and orientation problems.

The **Personal Experience Screening Questionnaire (PESQ)** is the third tool in the battery. This 38-item questionnaire screens for the need to further assess, and to make appropriate referrals. It is useful for programs that only screen for AOD abuse problems and do not conduct in-depth evaluations.

Developer

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Inquiries

1) Ken Winters (see above for address), or
2) Tony Gerard
   Western Psychological Services
   12031 Wilshire Blvd.
   Los Angeles, CA 90025
   (213) 478-2061

Purpose

- To assess the extent of psychological and behavioral issues with alcohol and drug problems.
- To assess psychosocial risk factors believed to be associated with teenage chemical involvement.
- To evaluate response bias or invalid responding.
- To screen for the presence of problems other than substance abuse, such as school problems, family problems, psychiatric disorder, etc.
- To aid in determining the appropriateness of inpatient or drug outpatient treatment.

Type of Assessment (Life Areas Assessed)

Part I: (129 items): The Chemical Involvement Problem Severity (CIPS) Section includes items on alcohol as well as other drug use and problems; provides problem severity scores for each of five "basic" scales.

1. Personal Involvement with Chemicals (29 items) on frequency of use, use in inappropriate settings, use for psychological benefit or self-medication, and planning activities to allow use (preoccupation with use).

2. Effects from Use (10 items) on the immediate psychological, physiological, and behavioral consequences of chemical use.

3. Social Benefits Use (eight items) on use for increased social confidence and social acceptance.

4. Personal Consequences (11 items) on difficulties with friends, parents, school, and various other social institutions that result from the use of chemicals.

5. Polydrug Use (eight items) on indicators of use of drugs other than alcohol.

The CIPS also provides problem severity scores for each of five clinical scales:

1. Transituational Use (nine items) on use in a variety of settings, particularly ones that are inappropriate for drug use (such as school).

2. Psychological Benefits Use (seven items) on the use of chemicals to reduce negative emotional states and to enhance pleasure.

3. Social-Recreational Use (eight items) on the use of chemicals for fun in social situations.

4. Preoccupation with Use (eight items) on preplanning future use, restructuring activities to better allow private or social use, and rumination about use.

5. Loss of Control (nine items) on the inability to abstain when chemicals are available.

There are also three "Validity Indices" in the CIPS:

1. Infrequent Responses (seven items) associated with "faking bad," inattention, or random responding.

2. Defensiveness (15 items), a short form of the Crowne Social Desirability Scale, a frequently used measure of defensiveness.

3. Pattern Misfit statistically identifies respondents with unusual pattern response on the Personal Involvement scale.

Part II: (147 items): the Psychosocial Section (PS) section of the PEI includes:

- Eight Personal Risk or Personal Adjustment Scales
- Four Family and Peer Environmental Risk Scales

- Six Problem Screens including: Eating Disorder, Sexual Abuse, Physical Abuse, Suicide Risk, Psychiatric Referral

Brief descriptions of the 12 scales follow:

Personal Adjustment Scales

1. Negative Self-Image (10 items): This scale reflects general self-esteem and self-regard, personal satisfaction, and feelings of competence.

2. Psychological Disturbance (10 items): Items from this scale are associated with psychological problems and distress, such as difficulties with mood, thinking, and physical concerns.

3. Social Isolation (eight items): This scale represents competence, feelings of belonging to a social group, and degree of mistrust in one's social life.

4. Uncontrolled (12 items): These items focus on tendency to act impulsively, to display anger and aggressiveness, and to defy authority.

5. Rejecting Convention (11 items): The items in this set concern acceptance of traditional beliefs about right and wrong.

6. Deviant Behavior (10 items): High scores on this scale suggest involvement in unlawful or delinquent behavior.

7. Absence of Goals (11 items): This scale represents planning for and thinking about one's future plans, goals, and expectations.

8. Spiritual Isolation (seven items): High scores on this scale suggest absence of spiritual beliefs.

Family and Peer Environment

9. Peer Chemical Environment (eight items): The items defining this scale indicate involvement with chemicals by one's peers.

10. Sibling Chemical Use (four items): This set represents chemical use by brothers or sisters.

11. Family Pathology (14 items): Items from this scale are associated with family problems of chemical dependency, physical or sexual abuse, and severe family dysfunction.

12. Family Estrangement (nine items): This scale reflects lack of family solidarity and closeness, and presence of parent-child conflict.

Reading Level

6th grade

Credentials/ Training

Since the PEI is self-administered and instructions are provided, a formal training program is not essential. The PEI is available to "qualified professional users" as defined by the ethical standards of the American Psychological Association.

Training for a group at a program's site is offered by the Johnson Institute, for a cost of $2,000 (1-800-231-5165). Training workshops are also offered by Ken Winters, coauthor of the PEI (612-626-2879).

The dates and the fees for these workshops are negotiable.

Completion Time

45-60 minutes

Scoring Procedure

IBM-compatible software package for on-site scoring or a mail-in service provided by Western Psychological Services (WPS). The report from WPS on the individual client includes the profile of scores obtained by the client and an interpretation narrative.

Scoring Time

Mail-in service turnaround time is the same working day after receipt of materials.

General Commentary

Provides a list of critical items that suggest areas in need of immediate attention by the treatment provider and summarizes treatment indicators.

Additional data collected by the authors indicate that the scales appear to be reliable and valid for Black, Hispanic, and urban American Indians.

Access

Order from Western Psychological Services (See "Inquiries"). The PEI is copyrighted.

Pricing Information

PEI Kit (including Manual and 10 WPS Test Report forms) is $170.00 (or $165.00 for orders of 2 or more kits). PEI Manual = $32.50 (or $29.90 for orders of 2 or more manuals).

Assessment of Chemical Health Inventory (ACHI)

Introduction

This 128-item self-administered instrument, which can be taken and scored on an IBM-compatible personal computer, contains both alcohol- and other drug-related items, as well as Critical Life Items (10 items that indicate the client's need for immediate attention). It screens for random, inattentive, or inconsistent test-taking behavior and for defensiveness, exaggeration, or social desirability tendencies. It does not provide information about specific drugs used, amount of consumption, or frequency of use. The computer printout lists statements according to the client's responses (for example, strongly agree, agree, disagree, strongly disagree). Responses are *not* categorized according to content or problem area.

Although the ACHI can be taken or self-administered by the client on a personal computer (IBM or IBM-compatible microcomputer), it can also be administered in paper and pencil form without a computer.

Developer

Dan Krotz, M.A.; Richard Kominowski, B.S.; Barbara Bernston, M.S.W.; and James Sipe, Ph.D. Contact through James Sipe, President.

Inquiries

Recovery Software, Inc.
7401 Metro Blvd. Suite 445
Minneapolis, MN 55439
(612) 831-5835

Purpose

- To assess the nature and extent of substance abuse and associated psychosocial problems
- To develop a standard that will facilitate communication between treatment providers.

Type of Assessment

To aid in determining the appropriate type of treatment setting and program for the client, and to aid in making any indicated referral.

Life Areas and Problems

1. Family estrangement
2. Chemical use involvement
3. Personal consequence
4. Alienation
5. Social Impact
6. Depression
7. Family support
8. Family chemical use
9. Self-regard/abuse
10. Physical and/or sexual abuse

Subscale scores are provided for each of these factors. Three of the factors measure aspects of chemical or substance use and abuse: (a) "Use Involvement" (which includes degree of need for use, or compulsion to use, reasons for use, etc.); (b) "Personal Consequences" of use; and (c) "Social Impact" of use, including effects of chemical use on subject's relationships.

Reading Level

6th grade

Credentials/ Training

The ACHI is available to qualified users as determined by the usual standards applied to qualify for administration of educational and psychological tests.

A 1-day training seminar is available, to be provided to a group at the treatment program site, at a cost of $700 per day, plus travel cost. However, since the ACHI is a computer-interactive self-administered instrument that is

computer scored, no training in addition to use of the instruction manual may be required.

Completion Time

15-25 minutes

Scoring Procedures

Computer-scored

Scoring Time

A 4-7 page computer printout (IBM compatible) is generated in 2-4 minutes. The report provides client identification and demographic information, frequency and duration of AOD abuse, types of drugs used, critical life items, social desirability information, a ranking of scores for the various factors, and a listing of statements responded to affirmatively by the client. An enhanced report offers interpretive guidelines, level-of-care recommendations, and a validity check.

General Commentary

This instrument is included here, although it is the only instrument included that does not provide quantitative data on frequency or duration of use of specific illicit drugs. It does provide scores on degree of need for use of drugs, on reasons for use and on consequences of use. It is quick and easy to administer—it can even be self-administered on an IBM-compatible personal computer. A special feature is that it has been shown to reliably differentiate the relative severity of AOD abuse problems.

Access

Recovery Software, Inc.,
7401 Metro Blvd., Suite 445,
Minneapolis, MN, 55439
(612) 831-5835.

Pricing Information

A DOS-formatted demonstration floppy disk containing four computer-interactive administrations of the test, is available for $5.00, plus $3.00 for shipping. A "Starter Set," which includes the User Manual and a microcomputer floppy disk containing 25 administrations of the test, is available for $179.00. The tests, when purchased in sets of 50, are available for $5.75 each (a total of $287.50 for 50 tests).

Drug Use Screening Inventory (DUSI)

Introduction

The DUSI is a 149-item instrument that consists of: 1) a Personal History Form for documenting the client's background; 2) the Drug Use Screening Instrument, for assessment and comprehensive diagnostic evaluation; and 3) demographic, medical, and treatment/prevention summary plan.

As a self-administered instrument, it may not be appropriate for clients with limited reading ability in English or for those who are acutely or severely disturbed psychologically.

Developer

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Inquiries

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(412) 624-1070

Purpose

- To comprehensively evaluate the adolescent drug abuse client and his/her health, psychiatric, and psychosocial problems
- To identify or "flag" problem areas
- To quantitatively monitor treatment progress and outcome.

Type of Assessment

A decision-tree approach is used: "The information acquired from the DUSI should be viewed as implicative and not definitive in that the findings should generate hypotheses regarding the areas requiring comprehensive diagnostic evaluation" (by using other instruments). The DUSI is structured and formatted for self-administration, using paper and pencil or computer, by clients 11 to 21 years of age who are without communication and reading problems. It can also be group-administered.

Life Areas and Problems Assessed (Domains)

1. Substance Use Behavior
2. Behavior Patterns
3. Health Status
4. Psychiatric Disorder
5. Social Skill
6. Family System
7. School Work
8. Peer Relationship
9. Leisure
10. Recreation

Reading Level

6th grade vocabulary level

Credentials/ Training

Available to drug counselors and other qualified users.

Training

Usual standards for administration of educational and psychological tests and questionnaires. Since the DUSI is self-administered and instructions are provided, no training program is essential for either administrating or scoring of the instrument.

Completion Time

20 to 40 minutes (depending on the subject)

Scoring Procedures

An "Absolute Problem Density" score is obtained for each of the 10 domains, indicating the number of problem behaviors reported. The "Relative Problem Density" score indicates the severity of problems in each domain relative to

the overall number of problems endorsed ("yes" responses) by the client for all 10 domains. Thus, the total raw score summed across the 10 domains is obtained first. This score is then divided into the total number of endorsements obtained for each domain, and the dividend is multiplied by 100. The "Relative Density Score" for Domain IV (psychiatric disorder) is the percentage of all the psychiatric-psychological problems that are reported and endorsed by the client and listed in Domain IV of the DUSI. The "Summary Problem Index" indicates the overall severity of problems from the total universe of DUSI problems. This index or summary score indicates the absolute severity of all the problems of all types without reference to particular problem areas. Two graphical profiles can be constructed, based on the absolute and relative problem density scores. A computer scoring service is available, in addition to manual scoring and profiling at the user's facility by using a PC.

Scoring Time

15-20 minutes

General Commentary

The 10 domains or life areas used to determine the adolescent's problems are similar to those used by several of the other instruments described for adolescents. The "Relative Problem Density" score enables ranking of the relative severity of problem types across the 10 domains, and thus is an aid to developing an individualized treatment plan. This procedure is described as "Stage 3" in the three-stage "decision-tree" model that is described.

Access

The Gordian Group
P.O. Box 1587
Hartsville, SC 29950
(803) 383-2200
The DUSI is copyrighted.

Pricing Information

The prices for three administration formats are as follows: 1) DUSI paper questionnaires, requiring the use of an IBM-compatible PC: $2.00 each; 2) a DUSI Computer system: $495.00; 3) Opscan forms and scoring of 25 tests: $75.00.

The Prevention Intervention Management and Evaluation System (PMES)

Introduction

The PMES is a 150-item instrument, including items related to both alcohol and other drug problems, for administration in a structured interview shortly after admission to treatment. It "provides information considered theoretically significant for adolescent drug use and related problems" (Simpson and McBride, 1991).

Developer

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Inquiries

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(817) 921-7226
FAX (817) 921-7290

Purpose

1) To assess substance abuse and other life problems of adolescent clients; 2) to assist in planning treatment; 3) to provide followup assessment and evaluation data on treatment outcome.

Type of Assessment

The PMES consists of two main parts: The Client Intake Form (CIF), and the Information Form on Family, Friends, and Self (FFS). The information derived from these two parts is integrated in the effort to plan the treatment and determine the appropriate level of care for the client. In the structured interview format, the questions are read verbatim to the client.

Life Areas and Problems Assessed

The Client Intake Form includes 55 questions (items) that cover the following areas: client-identifying demographics, the referral source and process, socioeconomic and family background, school problems, legal status and problems, drug and alcohol use history, and a checklist for the interviewer to indicate in which of 10 problem areas the client needs help.

The 95-item Information Form on Family, Friends, and Self includes the following three parts:

A. The Family Relations Scale (39 items), measuring six dimensions: 1) control, 2) consistent parenting, 3) conflict, 4) trust and understanding, 5) care and support, and 6) affiliation. Despite a high correlation between the trust and understanding scores and the care and support scores, it is suggested that each dimension represents a distinct concept.

B. The Peer Activity Scale (35 items), measuring five dimensions: 1) peer activity level, 2) peers' legal involvement, 3) peers' school problems, 4) peers' familiarity with parents, and 5) peers' conventional involvement. Only the first dimension refers to the client's own activity with peers; the other four refer to the number of close friends involved in each type of activity or problem.

C. The Self Scale (21 items), measuring five dimensions of the client's psychological status: 1) self-esteem, 2) social satisfaction, 3) material satisfaction, 4) school satisfaction, and 5) job satisfaction.

Reading Level

6th grade

Credentials/ Training

The PMES is available to qualified users as determined by the usual standards for administration of educational and psychological tests. Since the PMES forms are self-administered and contain instructions, no user manual and no specific training program are required by personnel qualified to administer such instruments. While a brief training period of several hours' duration is advisable, it is not essential for adequately qualified personnel (such as drug counselors).

Completion Time

Approximately 1 hour.

Scoring Procedures

Each item of the FFS form is constructed in a Likert-type format in which the client is asked to indicate the degree to which, or the frequency with which, the particular behavior or attitude occurred.

By totaling item scores, 16 separate scores are derived for the life areas assessed. The scoring instructions are available, together with the PMES questionnaire forms, including all items and factors, from Dwayne D. Simpson, Ph.D. (See address and phone number above).

Scoring Time

10-15 minutes

Pricing Information

Copies of the PMES forms are thus far available without charge. The items and factors of the PMES can also be inspected in the professional paper written by Simpson and McBride (1991).

General Commentary

A strength of the PMES is that the score obtained for an individual client can be compared to the scores obtained by the normative sample. A relative weakness of the PMES is that it has not as yet had quite the in-depth psychometric development for establishing test-retest reliability and validity that some other instruments for assessing adolescent AOD abusers have had. Some assessors may like the fact that, compared to some of the other instruments, the PMES is not quite as long and complicated, and the items are relatively simple and easy to understand.

Access

D. Dwayne Simpson, Ph.D. (See address and phone number above.) The PMES is not copyrighted. Permission to photocopy the forms can be determined in discussion with Dr. Simpson.

Problem Oriented Screening Instrument For Teenagers (POSIT)

Developers

National Institute on Drug Abuse

Inquirers

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Purpose

The POSIT is a screening tool designed to identify potential problem areas that will require further in-depth assessment. Depending on the results of the in-depth assessment, treatment and related services may be necessary. The POSIT, when used for preliminary screening, can be utilized by a variety of assessors such as school personnel, court personnel, medical care providers, in addition to staff of AOD abuse treatment programs. (POSIT is not an appropriate tool for parents to use.) The POSIT, as presented in a comprehensive assessment-referral system, is not designed as a measure of change or as an outcome measure.

Introduction and Description

The POSIT was developed by a panel of expert clinicians as part of a more extensive assessment and referral system for use with adolescents aged 12-19 years (Rahdert, 1991). It was designed to identify problems and treatment needs in 10 areas, including substance abuse, health, mental status, and social relations.

Type of Assessment

The POSIT is a self-administered 139-item questionnaire designed for use with male and female adolescents 12-19 years old. Some questions are age-related in that they are scored only for respondents over 16. Some individual items are age-specific and handled differently in scoring than others. The POSIT is available in English and Spanish. The respondent answers "yes" or "no" by circling the response. Points are given for responses in each area, and cutoffs have been established to indicate the need for further attention. The POSIT can be used in conjunction with the Comprehensive Assessment Battery (CAB) (Henly and Winters, 1989).

Life Areas and Problem Assessment

The 10 functional areas identified in the POSIT are:

- AOD use and abuse
- Physical health
- Mental health
- Family relations
- Peer relations
- Educational status
- Vocational status
- Social skills
- Leisure/recreation
- Aggressive behavior.

Scores are developed for each content area independently.

Reading Level

6th grade

Credentials/ Training

The POSIT format is very clear and straightforward, and scoring templates are provided. No special qualifications are necessary to administer the POSIT.

Scoring Procedures

Scoring of the POSIT is done through simple scoring templates available for both English- and Spanish-language versions. The templates are placed over the complete questionnaire, and the high risk answer is indicated by a circle on the template. Final scoring is done by adding scores in each category. Some items are not scored for adolescents under 16 and are indicated by shaded template areas. Cutoff points in each area indicate scores beyond which additional help and/or diagnostic assessment are needed. If cutoff scores provided with the POSIT are not appropriate, a new set of cutoff scores can be developed at the site where the POSIT is used. These scores can reflect the problem profiles seen at the agency or program, or the scores can indicate the type of referral or treatment decisions that must be made by that agency or treatment program.

General Commentary

The POSIT is brief, easy to use, and specific to the problems and concerns of adolescents. It is not a diagnostic instrument and requires additional tests for full assessment. Some literacy is required.

Related Tests

Each problem area identified on the POSIT is addressed in depth by one or more of the assessment tools listed in the Comprehensive Assessment Battery (CAB). For example, for a more thorough assessment of substance abuse, the Personal Experience Inventory (PEI) (Winters and Henly, 1989), described in detail above, can be used. Both the POSIT and CAB are available in the Adolescent Assessment-Referral System (AARS) Manual.

Access

To obtain a copy of the POSIT, order the Adolescent Assessment-Referral System Manual, DHHS Publication No. (ADM) 91-7135, through the National Clearinghouse for Alcohol and Drug Information, P.O. Box 2345, Rockville, MD 20847-2345, 1-800-729-6686.

Instruments for Assessment of Life Domains and Problem Areas

There may be a need for a more in-depth and definitive diagnostic assessment of one or more particular areas of the client's behavior, functioning, or status than can be provided by any of the broad-spectrum instruments reviewed in this document.

For example, for those clients who have serious psychological, psychiatric, or emotional problems in addition to AOD abuse (usually referred to as "dually diagnosed," or as having a "comorbid" condition), none of the recommended broad-spectrum instruments are sufficient for establishing a definitive DSM-III-R diagnosis. There are available structured psychiatric interview instruments that have been developed specifically for this purpose, such as the DICA-R for adolescent clients and the SCID for adult clients. Aside from the question of dual diagnosis, the use of the SCID, for example, can determine whether the client is to be diagnosed and formally labeled as a drug "abuser," or as "drug dependent," according to the accepted DSM-III-R criteria.

Also, a more in-depth psychopathology scale, such as the Symptom Checklist-90 (SCL-90), or the Brief Symptom Inventory (BSI), may be useful as a standardized method for measuring the severity of various types of psychic symptomatology (such as anxiety, depression, psychosis, etc.). The latter type of instrument requires only 10 to 15 minutes to measure psychopathology. It is not, however, an adequate substitute for a current complete psychiatric status and psychiatric history obtained by the structured psychiatric interview.

A recommended list of "backup" instruments for the more definitive and in-depth diagnostic evaluation of each of a number of client problem areas is presented below. The criteria that have been utilized for the selection of these instruments are, as indicated earlier, the adequacy of their psychometric development, appropriateness for the adolescent client population, and the adequacy and comprehensiveness of their evaluation of a particular type of life problem.

The information derived by initial use of a broad-spectrum instrument may indicate at least a moderate problem in a particular domain of the client's life. In such instances, the program may wish to explore that area more thoroughly and more definitively. An overview of instruments for assessment of life domains and problem areas is presented on the next page.*

The remainder of this section groups the instruments according to the seven life domains and problem areas as described on the overview that follows. These domains are organized as 1) substance use and abuse diagnosis and related domains, 2) medical/physical health (status and problems), 3) school (status and problems), 4) social/lifestyle/peer relationships, 5) family (relationships and problems), 6) psychological/psychiatric problems (mental health status, diagnosis, and disorder).

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* The recommendations of specific instruments that were included in three such similar lists (Benishek, 1989; Rahdert, 1990; and Tarter, 1990) have been considered in the process of developing this list.

Overview of Instruments for Assessment of Life Domains and Problem Areas

Domain		Instruments
1.	Substance Use and Abuse Diagnosis and Related Domains	• American Drug and Alcohol Survey (ADAS) Oetting, E.R. and Beauvais, F. (1990 • The Chemical Dependency Assessment Profile (CDAP) Harrell, T.H. et al. (1989) • Quantitative Inventory of Alcohol Disorders (QIAD) Ridley, T.D. and Kordinak, S.T. (1988) • The Adolescent Drinking Index (ADI) Harrell, T.H. et al. (1989) • The Michigan Alcoholism Screen Test (MAST) Selzer, M.L. (1971); Zung, B.J. (1982) • The Revised Diagnosis Interview for Children and Adults (DICA-R); Structured Clinical Interview for Diagnosis (SCID) Reich, W. et al. 1990; Spitzer, R.L. et al. (1990)
2.	Medical/Physical Health (Status and Problems)	• A physical examination and a Physician Report Form Rand General Health Rating Inventory (GHRI) Davis, A.R. and Ware, J.E., Jr. (1981); Ware, J.E. Jr. (1976) • Cornell Medical Index Health Questionnaire (CMI) Brodman, K., Erdman, A., Lorge, I. and Wolf, H. (1949)
3.	School (Status and Problems)	• The Quality of School Life Scale Epstein, J.L. and McPartland, J.M. (1977)
	Reading, Spelling, and Arithmetic	• Wide Range Achievement Test (WRAT-R) Jastak, S.F. and Wilkinson, G.S. (1984)
4.	Social/Life Style/ Peer Relationships	• The Revised Problem/Behavior Problem Checklist Hagbord, W.J. (1990) • The Youth Self-Report (Adolescent Version of the Child Behavior Checklist, CBCL) Achenbach, T.N. (1991)
5.	Family (Relationships and Problems)	• Family Environment Scale (FES) Moos, R.H. (1974) • Family Assessment Measure (FAM) Skinner, H.A. et al. (1983) • Family Satisfaction Scale Olson, D.H. and Wilson, M. (1982) • The Family Crisis-Oriented Personal Evaluation • Scales (F-COPES) McCubbin, H. et al. (1982) • Adolescent-Parent Communication Form Olson, D. et al. (1982)
6.	Psychological/Psychiatric Problems (Mental Health Status; Diagnosis, Disorder)	• The Brief Symptom Inventory (BSI) Derogatis, L.R. and Melisaratos, N. (1983) • Maudsley Neuroticism Scale Eysenck, H.J. (1959) • Diagnostic Interview for Children and Adolescents (DICA-R) Welner, Z. et al. (1987) • Kiddie Schedule for Affective Disorders and Schizophrenia (K-SADS) Orvaschel, H. et al. (1982) • The Diagnostic Interview Schedule for Children (DISC-2C) Costello, A. et al. (1984)
7.	Delinquency/Illegal Behavior	• The National Youth Survey (NYS) Elliott and Ageton (1985) • Law Encounter Severity Scale (LESS) Witherspoon, A.D. et al. (1973) Jenkins, W.O. et al. (1974)

1. Substance Use and Abuse Diagnosis and Related Domains

Some of the instruments described in this section do not provide a more comprehensive assessment of AOD abuse behavior and history-related problems than is provided by each of the five broad spectrum instruments described earlier. (For example, the Chemical Involvement Problem Severity (CIPS) section of the PEI instrument, described earlier, provides as much information as any of the instruments listed in this section.) The instruments in this section do provide different types of information relevant to AOD abuse problems. Accordingly, if one of these instruments is used in conjunction with one of the five broad spectrum instruments, a more complete picture of the AOD abuse history and problems will be obtained.

The types of instruments available for assessment of AOD use and abuse may be classified as either: 1) for the measurement of the frequency, amount, and duration of use of the various types of substances, and of the problems related to the use/abuse, or 2) for the determination of the presence (in the past or in the present) of a condition that is formally diagnosed in a medical sense, based on DSM-III-R criteria, and that should be labeled as either "drug abuse" or "drug dependency" or "alcohol abuse" or "alcohol dependency." Most drug treatment programs do not need to use the second type of instrument to establish a formal diagnosis for most of their clients, either as a criterion for admission to the program or for other purposes. In other situations, it is useful to use the second type of instrument, as in determining whether to admit a client to inpatient treatment for detoxification, and whether a client is currently in a state of dependency. In such instances, both types of instruments should be used, or the second diagnostic type of instrument should be used in combination with one of the broad spectrum instruments described earlier.

The four best known diagnostic instruments currently available for use with adolescents are: (1) DICA-R-A; (2) DISC-2C; (3) K-SADS; and (4) CAPA. The SCID, which is used primarily for adults, can also be used with adolescents. The language of the questions in the SCID is, however, not quite as appropriate for adolescents. Some of these instruments only determine a diagnosis based on the whole lifetime behavior of the client, and some determine additionally whether the recent and current behavior warrants a diagnosis of "abuse" or "dependency." The latter is clearly preferable for treatment planning. We have selected the DICA-R-A for presentation below, as arguably the most recently and fully developed of such instruments.

The DICA-R-A instrument for adolescents, (Reich et al., 1991), as well as the SCID instrument (Spitzer et al., 1990) (which is described in the section on backup instruments for adults) both use the DSM-III-R diagnostic criteria for enabling the interviewer to either rule out or to establish a diagnosis of "drug abuse" or "drug dependence" and/or "alcohol abuse" or "alcohol dependence." The DSM-III-R criteria for substance abuse diagnoses are the same for adolescent as for adults. The questions on the DICA-R are worded somewhat more appropriately for adolescents. These diagnoses can be made by the examiner asking a series of approximately 10 questions of a client. The DSM-III-R criteria for determining a diagnosis of "Psychoactive Substance Abuse" are summarized as follows: A. A maladaptive pattern of psychoactive substance use indicated by at least one of the following: 1) continued use despite knowledge of having a persistent or recurrent social, occupational, psychological, or physical problem that is caused or exacerbated by use of the psychoactive substance; 2) recurrent use in situations in which use is physically hazardous (for instance, driving while intoxicated). B. Some symptoms of the disturbance have persisted for at least 1 month, or have occurred repeatedly over a longer period of time.

The criteria required for establishing a DSM-III-R diagnosis of dependency are more severe than required for abuse. Two of these criteria, for example, are: 1) "Characteristic Withdrawal Symptoms," and 2) "Marked Tolerance" (need for at least a 50 percent increase in the amounts of substance used to achieve intoxication or desired effect). (There apparently are no normative data available as yet, based on a general population sample, for either adolescents or adults).

The American Drug and Alcohol Survey (ADAS) (Oetting and Beauvais, 1990). This 57-item self-report instrument (which covers more information than any of the recommended screening instruments for adolescents) includes: 1) use/abuse of 36 different types of substances during the preceding 12-month period; 2) lifetime use; 3) frequency of "getting high" with each substance; 4) the places or situations in which use occurred; 5) accessibility of each type of substance; 6) perceived harmfulness of substances; 7) problems caused by substance use; and 8) involvement with peers in substance use (substance use lifestyle). Normative data are available based on survey data collected from approximately a half million students in grades 7 through 12 in schools in 37 States. Ethnic minority students are adequately represented in this large high school sample, and there is a particularly large sample of Native American students from a number of different tribes located in the western States. Over 100,000 students were surveyed in 1988-1989.

The high reliability of this instrument is supported by its internal consistency. It requires 20 to 25 minutes to complete. A special feature of the ADAS is the development of a typology of nine "styles" of use of drugs, in various combinations, of types of drugs. These "styles" are hierarchically listed in order of increasing severity of drug involvement. Items that were found not to be reliable through several revisions, in all ethnic groups, were eliminated. The 1988 survey sample included 8,165 white students, 1,512 Mexican-Americans, 446 western Spanish Americans, 325 reservation Native Americans, and 2,025 students in a rural subsample.

For checking for inconsistency or random responding to ADAS items, 34 different types of checking were conducting; for example, 1.6 percent of the students reported use of a fictitious drug, and 3.8 percent were estimated to have exaggerated their drug use.

The cost for the ADAS forms is $1.00 for the forms required for an individual subject.

Access: RMBSI, Inc.
2190 W. Drake Road., Suite 144
Ft. Collins, CO 80526

The Chemical Dependency Assessment Profile (CDAP) (Harrell, Honaker, and Davis, 1991) is a 235-item, multiple-choice and true-false self-report instrument to assess alcohol and other drug use and chemical dependency problems. The 11 dimensions measured include: quantity/frequency of use, physiological symptoms, situational stressors, antisocial behaviors, interpersonal problems, affective dysfunction, attitude toward treatment, degree of life impact, and three "use expectancies" (that is, the client's expectation that use of the substance reduces tension, facilitates socialization, or enhances mood. An example of a "use expectancy" item is: "I get aggressive or violent when using alcohol.").

This instrument probably develops as much detailed information related to substance use, abuse, and dependency as any of the others described in this manual. There are 90 items on alcohol use and problems alone. The questionnaire covers chemical use history, patterns of use, reinforcement dimensions of use, perception of situational stressors, and attitudes about treatment, self-concept, and interpersonal relations.

Normative data are available thus far on only 86 subjects, including 31 polydrug abusers, 27 alcohol abusers, and 28 social drinkers. In this sample, there were 52 males and 48 females, with mean age of 35.3 years (Standard deviation [S.D.] = 11.6) and mean years of education of 13.2 years (S.D. = 3.1). The racial and ethnic distribution was 93 percent Caucasian, 4 percent Black, and 3 percent Hispanic.

The CDAP can be administered by computer, as well as in paper-and-pencil format, and a 3- to 8-page computerized report can be generated. This report includes the subscale scores for the 11 dimensions.

Test items are available at the following costs: $22.00 for a package of 20 forms for paper-and-pencil administration; and $200.00 for the IBM software for computer administration.

Access: Multi-Health Systems (MHS) Publishers
65 Overlea Blvd.
Toronto, Ontario
M4H-1P1 Canada
1-800-456-3003

Adolescent Drinking Index (ADI) (Harrell et al., 1989). The ADI is a brief 24-item self-report rating scale that can be completed in about 5 minutes by adolescents with 5th grade reading skills or better. The main purpose of the instrument is to provide a screening index to ascertain the relative severity of AOD abuse and its associated behavioral and psychological problems. The quantitative data obtained by the instrument on frequency, amount, or duration of alcohol use is minimal, derived from 8 of the 24 items. Most of the items relate to reasons for drinking and symptoms and behavior associated with drinking.

Test items are available at the following costs: $35.00 for the ADI Kit (including manual and 25 test booklets); $9.00 for the ADI manual alone; and $30.00 for a package of 25 test booklets.

Access: PAR Psychological Assessment Resources, Inc.
P.O. Box 998
Odessa, FL 33556
1-800-331-TEST

Michigan Alcoholism Screening Test (MAST) (Selzer, 1971). The MAST is a relatively simple, inexpensive, and widely used alcoholism screening instrument designed principally to provide a quantifiable, structured interview instrument for the detection of alcoholism. It has been widely used with many different subject groups, such as alcoholics, persons convicted of driving while intoxicated, other social or problem drinkers, other drug abusers, psychiatric clients, and general medical clients. It may be of limited validity with some populations. It consists of 25 questions that require a simple "yes" or "no" answer. It can be administered in about 7 minutes.

Test items are available from the source listed below (either without cost or at nominal cost).

Access: Melvin L. Selzer, M.D.
University of Michigan Medical School
Ann Arbor, MI 48104

Drug Abuse Screening Test (DAST) (Skinner, 1982). This 20-item questionnaire, constructed similarly to the Michigan Alcoholism Screening Test (MAST), yields a quantitative index of degree of problems related to illicit drug use or abuse. Like the MAST for alcohol use or abuse, it does not collect information on frequency or duration of use of specific substances. It takes approximately 5 minutes to complete, and may be given either in self-report or interview format. A factor analysis of the 20 items indicates that the DAST is essentially a unidimensional scale.

The DAST form and scoring key are available (either without cost or at nominal cost) from:

The Addiction Research Foundation
33 Russell Street
Toronto, Ontario M5S-2S1.

Access: Harvey A. Skinner, Ph.D.
Department of Behavioral Science
Faculty of Medicine, McMurrick Building
University of Toronto
Ontario, M5S-1A8

Manson Evaluation (ME) Revised (Manson and Huba, 1987). This 72-item instrument has been administered to more than a quarter of a million individuals for use as a screening measure of alcohol abuse. It also measures anxiety, depression, depressive fluctuations, emotional sensitivity, resentfulness, aloneness, and quality of interpersonal relations. Five to 10 minutes are required for either individual or group administration. The test form is easy to use and has a unique AutoScore system, which makes it possible to score, profile, and interpret the test in just a minute or two. A Probability Index for Alcohol Abuse Proneness indicates the degree to which the subject is abuse prone. Scoring can be done by computers and interpretive reports generated.

Test items are available at the following costs: The kit includes 25 test/profile forms and one manual: one kit, $45.00; two or more kits, $41.80 each. The test/profile (packages of 25): one package, $27.50; two to nine packages, $25.30 each; 10 or more packages, $24.15 each. The manual: $18.50; two or more, $16.90 each; one to nine answer sheets, $14.50 each; 10-99 answer sheets, $13.25 each; and 100 or more answer sheets, $12.75 each. For computerized administration (25 times the cost of the disk): $185. This program will also score the tests and complete an interpretive report.

Access: Western Psychological Services
12031 Wilshire Blvd.
Los Angeles, CA 90025
(213) 478-2061

The Quantitative Inventory of Alcohol Disorders (QIAD) (Ridley and Kordinak, 1988). This 22-item self-report instrument, in which each item is rated on a 5-point scale, can be completed in 10 to 12 minutes. It assesses the severity of an alcohol problem (the frequency and duration of drinking, the type and amount of alcohol consumed). The QIAD does not collect information on any other drugs, only alcohol. Since it measures alcohol use and related problems that occur during the 1-month period preceding administration, it is possible to determine the degree of increase or decrease that occurs in the problem by readministering the QIAD at a later time. It also measures the problems related to alcohol use in the following types of behavior and performance: occupational, physiological, legal, emotional, and social. A descriptive title for each item aids the respondent's understanding of the item. There is a simple scoring system based on summing the points for each item.

This instrument has apparently not been marketed. A copy of the instrument, and of the manual, if one is available, probably can be obtained at little or no cost from the authors, listed below.

Access: T.D. Ridley and S.T. Kordinak

2. Medical/Physical Health Domains (Status and Problems)

General Health Rating Index (GHRI) (Davis and Ware, 1981; Ware, Jr. 1976; Ware, et al., 1984). This 23-item self-administered questionnaire measures "perceptions of past, present and future health status, as well as worry about health and personal views regarding susceptibility to illness." This questionnaire, which requires approximately 7 minutes to complete, differs from other instruments for evaluating health status in that it does not include items on specific illnesses, diseases, symptoms, or components of health. It appears to assess the physical and social role limitations due to poor health and/or acute physical and psychiatric symptoms. This instrument was used in the Rand Health Insurance Study (HIS) on a sample of 4,444 adults and children in six sites in four States. Norms for various age groups and for the two genders are available based on the general populations of these four States, including representation from various minority ethnic groups.

Administration time for the GHRI is 10 minutes.

A copy of the GHRI form and of the norms for scoring have been available thus far at no cost.

Test items are available from the source listed below (either without cost or at nominal cost).

Access: Dr. John E. Ware, Jr.
The Rand Corporation
1700 Main Street
P. O. Box 2138
Santa Monica, CA 90406

Cornell Medical Index Health Questionnaire (CMI) (Brodman, Erdman, Lorge, and Wolf, 1949). This instrument can be self-administered or read to the individual, who responds with "true" or "false" statements about the presence or absence of specific medical symptoms or difficulties. In about 20 to 30 minutes, the 195 items review each of the major physical systems and thus offer a comprehensive indication of the client's medical status. The inventory has been widely used, serving as a screening instrument that can show whether the individual needs referral to a physician for more intensive medical care. There are 57 items that address psychological/psychiatric elements, which may be omitted if an instrument such as the SCL-90 is also part of the assessment.

Test items are available from the source listed below (either without cost or at nominal cost).

Access: The Psychological Corporation
555 Academic Court
San Antonio, TX 78204-2498
1-800-228-0752

3. School Domains (Status and Problems)

The Quality of School Life Scale (QSL) (Epstein and McPartland, 1978). This self-report questionnaire of 14 true-false items, 9 multiple choice items, and 4 rating scale items is a "multidimensional measure of student reactions to school in general, to classwork, and to teachers." It yields three subscale scores: 1) "satisfaction with school"; 2) "commitment to classwork"; 3) "reactions to teachers." It has been shown not to be positively significantly related to scores on standard achievement test scores or to socioeconomic status of students. However, it is negatively correlated to "anxiety about school" (r = -.43). This instrument was standardized on a student population of diverse backgrounds. The completion time is 10 minutes.

Test items are available at the following costs: $20.00 for a kit including an instruction manual, scoring key and test booklet; and $8.79 for 35 test booklets.

Access: Riverside Publishing Company
8420 Bryn Mawr Avenue,
Chicago, IL 60631

The Wide Range Achievement Test Revised (WRAT-R) (Jastak and Wilkinson, 1984). This is a well-standardized test that is widely used with children, adolescents, and adults for a quick evaluation of reading, spelling, and arithmetic skills and performance. Two levels of the test are available: Level 1 (ages 5 - 11) and Level 2 (ages 12 - adult). It is a time-limited test with 5 to 10 minutes allowed for each of three sections. Norms based on a national, stratified sample (including varied ethnic and racial groups) are available for raw scores, grade equivalents, standard scores, and percentile ranks. The test is scorable by hand.

Test items are available at the following costs: Manual (administration and scoring), $24.00; level 1 test forms (package/25), $16.00; level 2 test forms (package/25), $16.00; reading/spelling plastic cards, $11.00; and reading/spelling tape cassette, $25.00.

Access: Sarah Jastak, Ph.D.
Jastak Assessment Systems
1526 Gilpin Avenue
Wilmington, DE
(302) 652-4990

4. Social/Life Style/Peer Relations Domains

The Revised Behavior Problem Checklist (RBPC) (Quay and Peterson, 1987; Hagbord, 1990). This is an 89-item checklist that includes a 17-item "Socialized Aggression" subscale for measuring the deviance in attitudes and behaviors of the adolescent's peer group, and the types of persons that the adolescent client admires. This instrument also includes five other subscales, of which the first three listed are relevant to problematic social behavior: 1) conduct disorder (22 items); 2) attention problems-immaturity (16 items); 3) motor excess (five items); 4) anxiety withdrawal (11 items); and 5) psychotic behavior (six items).

A 1987 manual is available that includes the scoring instructions (which are simple), the norms, and detailed psychometric data. A practical disadvantage, which may rule out use of this instrument in many instances, is that it is not planned for self-report by the adolescent or for an interview of the adolescent, but only for completion by an adult who knows the adolescent well (parent, teacher, etc.).

Administration time for the checklist is approximately 10 minutes. It can be scored in about 5 minutes.

Test items are available at the following costs: A kit (including manual, 50 checklists and scoring key) for $38.00. Each of these items is also sold separately: manual, $15.00; 100 checklists, $30.00; and scoring key, $9.00.

Access: (PAR) Psychological Assessment Resources, Inc.
P.O. Box 998
Odessa, Fl 33556
1-800-331-8378

Inquiries: Herbert C. Quay, Ph.D.
P. O. Box 248074
University of Miami
Coral Gables, FL 33124

The Youth Self-Report (YSR) (Achenbach, 1991). This is a 112-item instrument for adolescents (11 to 18 years of age) to report their competencies and problems. It thereby obtains an adolescent's own views of his/her own functioning. It yields two competency scale scores (activities and social relationships) and seven problem scores. The problem scores are:

- Depressed
- Unpopular
- Somatic complaints
- Self-destructive/identity problems
- Thought disorders
- Delinquent, aggressive.

The YSR takes about 15 to 20 minutes to complete and requires a fifth grade reading ability. "The YSR has also been found to correctly classify 82% of a sample of 1,300 referred and 1,300 non-referred ("normal") children according to DSM-III-R diagnostic criteria" (Auchenbach and Edelbrock, 1981). The subscales of the YSR that might appear to be most relevant for assessment of drug-abusing adolescents are: "delinquent" and "aggressive." These two problem scales, together with the "social" competence scale, can add to the evaluation of an adolescent's social lifestyle problem area. The remaining five problem scales of the YSR can add to the evaluation of the psychological problem area of the adolescent client.

Test items are available at the following costs: YSR forms and hand-scored profiles, $0.32 each; manual (221 pages), $25.00; IBM and Apple II computer scoring programs (optional) $20.00.

Access: T.M. Achenbach, Ph.D.
University Associates in Psychiatry
One S. Prospect Street
Burlington, VT 05401-3456

Social Intelligence Test (SIT) (Moss, Hung, and Omwake, 1990). This test, intended to evaluate the subject's social perceptions and sensitivity, consists of items about which the individual is asked to express an opinion. An examiner is required for administration. Five factors are measured:

- Judgment in social situations
- Recognition of the mental state of another person
- The feelings that another person is experiencing
- Accuracy when observing human behavior
- Memory for names and faces
- Sense of humor.

Percentile norms are provided separately for high school, college, and adult populations, by means of which a client's social perceptions and sensitivity can be evaluated.

Administration time is 50 minutes. A hand key is available for scoring. The cost of a specimen set of test materials is $5.00.

Access: Institute of Psychological Research, Inc.,
34 Fleury Street West
Montreal, Quebec, Canada H3L-929
(514) 382-3000

The Center for Psychological Service,
1151 K Street, N.W., Suite #430
Washington, D.C., 20005
(202-347-4069)

5. Family Domains (Problems)

The Family Environment Scale (FES) (Moos and Moos, 1981). This is a "whole family" assessment, an instrument that measures the family environment or climate. This 90-item self-report questionnaire includes 10 subscales each composed of 9 items; each subscale is, in turn, composed of three primary domains:

- Personal growth (independence, achievement orientation, intellectual-cultural orientation, active recreational orientation, moral-religious emphasis)
- Family interaction and relationships (cohesion, expressiveness, conflict)
- System maintenance dimensions (organization, control).

Three different test booklets are available: the "Real" form, which measures an individual's perception of the family as it is; the "Ideal" form, which asks the individual how the family should be; and the "Expected" form, which asks the individual to predict family behavior in new situations. Administrative time of the test ranges from 15-20 minutes.

Norms are available, based on 285 families of various sizes and including adequate numbers of African-American and Mexican-American families, but families of low socioeconomic status are under-represented in this original normative sample. As reported by Moos (1990), "The FES subscales generally show adequate internal consistency, reliability, and stability over time when applied in samples that are diverse; the items also have good content and face validity."

Test items are available at the following costs: 1 package of 25 form I test booklets, $16.00; 1 package of form R test booklets, $15.00; 1 package of 50 answer sheets, $10.00; 1 package of 50 profiles, $7.00; scoring key, $7.00; manual (1986), $13.00; user's guide, $9.00.

Access: Consulting Psychologist's Press, Inc.
577 College Avenue,
Palo Alto, CA 94306

The Family Assessment Measure (FAM-III) (Skinner, Steinhauser, and Santo-Barbara, 1983). This measure was developed to provide quantitative indices of family strengths and weaknesses. It is a 134-item self-report instrument that can be completed by a parent and child with adequate reading ability in approximately 45 minutes. The most recent version, FAM-III, consists of three scales, each of which provides a different perspective on the family: (1) a 50-item "General Scale" examines overall family health; (2) a 42-item "Dyadic Relationships Scale" measures how each family member views independently the dyadic relationships of each family dyad; and (3) a "Self Scale" (42 items), which reports the family member's perception of his or her functioning in the family. FAM-III also has seven subscales to assess dimensions of family functioning and status:

- Task accomplishment
- Role performance, communication
- Affective expression
- Involvement; control
- Values and norms (including specific cultural influences and values handed down from earlier generations).

The FAM-III also includes subscales to measure the response biases ("Denial/Defensiveness") of the individual family member completing the form "Social Desirability."

Norms based on 247 normal adults and 65 normal adolescents, as well as clinical families, are available by writing to Dr. Harvey Skinner (see address below).

Test items are available at the following costs: $75.00 for a starter set, which includes: 5 of each of three forms of test booklets, 50 general answer sheets, 75 dyadic answer sheets, 50 self-rating answer sheets, 25 "general scale" profile sheets, 50 "dyadic" and self-rating profile sheets, and one guide (manual).

Inquiries: Lisa Johnson or Harvey A. Skinner
Addiction Research Foundation
33 Russell St.
Toronto, Ontario, Canada, M5S-251

Access: Multi-Health Systems (MHS) Publishers
65 Overlea Blvd.,
Toronto, Ontario
M4H-1P1 Canada
1-800-456-3003

The prices for a complete kit, which includes a User's Manual, were made available during summer 1992.

Family Satisfaction Scale (FSS) (Olson, McCubbin, Barnes, Larsen, Muxen, and Wilson, 1982). This brief instrument consists of 14 items, each of which is a 5-point rating scale measuring the degree of satisfaction in 14 different aspects of family life. The theoretical model on which this instrument was constructed rests in two underlying factors: family cohesion and family adaptability. The focus of the items is on the subject's degree of satisfaction with the amount of the cohesion and the amount of adaptability perceived in the family.

The norms for this scale were derived from the scores obtained in it by 412 adolescents who participated in a national survey of families who were "primarily Caucasian and Lutheran." The standardization sample was 433 university students.

Test items are available from the source listed below at nominal or at no cost.

Access: Family Social Science
290 McNeal Avenue
University of Minnesota
St. Paul, MN 55108

The Family Crisis-Oriented Personal Evaluation Scales (F-COPES) (McCubbin, Larson, and Olsen, 1982) is a brief 29-item, five-subscale inventory that measures two types of family coping mechanisms: internal ("the ways in which the family handles difficulties and problems that arise between family members)"; and external ("the ways in which the family handles problems and demands that come from the social environment"). The five subscales are:

- Acquiring social support
- Reframing (defined as "the family's capability to redefine stressful events in order to make them more manageable")
- Seeking spiritual support
- Mobilizing the family to acquire and accept help
- Passive appraisal.

The prefix for all items is, "When we face problems or difficulties in our family, we respond by [-item-]." The F-COPES can be readily completed by most subjects over 12 years of age. Norms are available separately for males and females, and for adolescents and adults.

Access: A Manual, entitled *Family Inventories: Inventories Used in a National Survey of Families Across the Family Life Cycle* is available from:

David H. Olson, Ph.D.
Family Social Science
290 McNeal Avenue
University of Minnesota
St. Paul, MN 55108 at a cost of $37.50.

The forms required for administering the F-COPES (as well as the ENRICH and the Parent-Adolescent Communicating instruments) are presented in this manual, and may be photocopied with the permission of Dr. Olson.

Adolescent-Parent Communication Form (Olson, McCubbin, Barnes, Larsen, Muxen, and Wilson, 1982). This is a brief 20-item assessment instrument that can be completed by the average client in approximately 10 minutes. It focuses on family communication as reported by each of three family members (the adolescent client and each parent). It taps both content and process issues related to communication on three dimensions: open communication, problem communication, and selective communication. Communication, as a construct, is accepted in systems theory as one of the most important aspects of interpersonal and family relationships (Goffman, 1959; Russell, 1977). The final standardization sample was 417 high school and college students in Minnesota and Wisconsin. The Parent Adolescent Communication Form was found to significantly predict improvement after outpatient drug treatment as measured by reduction in substance use and abuse (Friedman et al. 1991).

Test items are available from the source listed below (either without cost or at nominal cost).

Access: Family Social Science
290 McNeal Avenue
University of Minnesota,
St. Paul, MN 55108

6. Psychological/Psychiatric Problems Domains (Mental Health Status; Diagnosis; Disorder)

NOTE: An approach that is frequently recommended for investigating the possibility of a significant mental health or psychiatric problem is to administer both a DSM-III diagnostic classification structured interview procedure and a self-report instrument (for example, the SCL-90 or the BSI described below) that provides scores on degrees and types of symptomatology.

The Brief Symptom Inventory (BSI) (Derogatis and Melisaratos, 1983). This is a 53-item short form of the 90-item SCL-90 inventory of psychiatric symptoms and psychopathology. The BSI appears more often to be used in studies of adolescents (possibly because they tend to be aware of and to report fewer symptoms than adults), while the SCL-90 is more often used in studies of adult clients or subjects. The BSI measures the psychopathology of the same nine dimensions as the SCL-90: (1) somatization, (2) obsessive-compulsive, (3) interpersonal sensitivity, (4) depression, (5) anxiety, (6) phobic anxiety, (7) hostility, (8) paranoid ideation, and (9) psychoticism. It also yields three global scores: (1) Global Severity Index (GSI), (2) Symptom Distress Index (SDI), and (3) Total Positive Symptoms.

Two normative samples were developed: (1) 2,408 (nonclient) high school students, and (2) 1,900 adolescent-clients in drug treatment programs, including a high percentage of lower SES African-American clients. Separate norms are available on male and female clients, on outpatients and inpatients, and on male and female nonclients.

Test items are available from the source listed below (either without cost or at nominal cost).

Access: Clinical Psychometric Research, Inc.
P.O. Box 619
Ridgewood, MD 22139

The Maudsley Neuroticism Scale of the Maudsley Personality Inventory (MPI) (Eysenck, 1959). This scale is one of the most extensively used and researched personality assessment instruments available. However, a limitation of this neuroticism scale is that it is suitable only for the assessment of milder forms of psychopathology, and not suitable for assessment of major affective or psychotic disorders. Although it is brief, requiring 10 to 15 minutes to administer, the "Maudsley" is sufficiently reliable for individual use. The value of the MPI is derived in part from the years of intensive research and theory building on the dimensions of personality. Two relatively independent "Super Factors," "extroversion-introversion" and "neuroticism," were found to account for a large part of the variance in "personality." The Neuroticism scale is the one more specifically recommended for assessment of drug abuse clients.

Normative data for the MPI are available for several different types of populations, including: (1) 714 male and 350 female American "normals" (college students); (2) 1,931 British male and female employees (primarily blue collar workers); (3) 468 male and female psychiatric clients, as well as for a population of criminals. (The other demographic characteristics of these normative samples have not been provided.) Although there are no norms available specifically for adolescent subjects, the items of the inventory are appropriate for adolescents.

Test items are available at the following costs: 25 copies, $7.35; 100 copies, $27.25; 500 copies, $109.25; hand-scoring keys, $4.50; manual, $2.90; specimen set (manual and one copy of all forms), $5.80; set of hand-scoring keys, $7.00.

Access: EDITS: Educational and Industrial Testing Service,
Box 7234,
San Diego, CA 92107

H.J. Eysenck, *The Maudsley Personality Inventory*,
London: University of London Press, 1959

The Revised Diagnostic Interview for Adolescents (DICA-R-A) (Reich, Welner, Taibleson, and Kram, 1991). This is a structured interview for ruling out or establishing the DSM-III-R psychiatric diagnoses for adolescents from 13 to 18 years of age. The DSM-III-R criteria are currently the most widely utilized systematic method for establishing psychiatric diagnoses. The DICA-R-A is a "lifetime" interview with questions that refer to the entire life span of the subject and determine whether the subject ever had any of one or more 18 psychiatric conditions (diagnostic categories) that are covered. It includes some features of semi-structured interviews (such as probes), as well as structured questions, used when the subject does not appear to understand the question or gives a vague response. There is a DICA-R-A for interviewing the adolescent client, and a version for interviewing the parent(s) about the adolescent. The time required for completing each of these structured interview versions, to review all the criteria for all the diagnostic categories, is approximately 1-1/2 hours. While the reliability and validity work on the revised instrument (DICA-R) is still in progress, the authors currently state that "the agreement on diagnoses, as well as symptoms, looks very good." In one normative sample, 114 adolescents 12 to 16 years of age, who applied at pediatric and psychiatric clinics, were interviewed. Their mothers were also interviewed on the DICA. Findings suggest that the DICA is a reasonably reliable and valid instrument (Welner et al., 1987).

Test items are available at the following costs: $25.00 for a package that includes the child, adolescent, and parent versions of the DICA-R-A interview forms, the manual for scoring, and several published articles that further explain the instrument.

(For further information on the available 3-day training program, on video scripts, reprints, references, or a computerized version of the DICA-R):

Access: Wendy Reich, Ph.D.
Division of Child Psychiatry
Washington University School of Medicine
4940 Audubon Avenue
St. Louis, MO 63110
(314) 362-2436

The Diagnostic Interview Schedule for Children (DISC-2C) (Costello, Edelbrock, Dulcan, Kalas, and Klaric, 1984). This is a structured psychiatric interview procedure determining DSM-III psychiatric diagnoses, as does the K-SADS (Kiddie Schedule for Affective Disorders and Schizophrenia). It reviews symptoms manifested during three different time periods:

- The preceding 6 months
- During a lifetime
- Currently.

There is a version for administering to a parent, which provides the advantage of validating the adolescent client's responses, or of determining the degree of consensus between parent and adolescent. Administration time is approximately 1 hour for the average adolescent.

(A definite recommendation has not as yet been made for selecting one of the two instruments described above for establishing a dual diagnosis for adolescent clients. There are relative advantages and disadvantages to each. For example, the DICA-R is the only one thus far that is based on the revised DSM-III-R diagnostic criteria. An advantage of the DISC-2C, on the other hand, is that it determines diagnoses for three different time periods.)

Test items are available from the source listed below (either without cost or at nominal cost).

Access: College of Physicians and Surgeons
Columbia University
722 W. 168th St.
New York, NY 10032

Beck Depression Inventory (BDI) (Beck and Ward, 1972). This instrument is widely used for assessing the degree of depression of psychiatric clients, and the possible existence of depression in other populations. Depression symptoms are very common in alcohol and drug abuse clients. The BDI is sensitive to measuring change in these clients as they respond to treatment. The instrument is quite brief, consisting of 21 multiple choice items. For each item, the respondents indicate which of four multiple-choice statements best indicate how they have been feeling over the last week.

The BDI was originally standardized on 598 psychiatric clients, but has since been applied to other populations.

The test is self-administered or it can be read to the client. The administration time is 5-15 minutes.

Test items are available at the following costs: A complete kit, which includes the instruction manual and 25 record forms, $41.00; one package of 100 record forms, $77.50.

Access: The Psychological Corporation
555 Academic Court
San Antonio, TX 78204-2498
1-800-228-0752

IPAT Depression Scale (Krug and Laughlin, 1976). This is a brief 40-item questionnaire that requires about 10 minutes to administer and is quite easy to score. It is standardized on over 1,000 individually diagnosed clients and on 1,900 nonclients. It is intended for adults of most educational levels.

Test items are available at the following costs: depression scale testing kit (contains manual, test booklet and scoring key), $12.95; depression scale manual, $9.25; test booklets, package of 25, $8.35; scoring key, $3.25.

Access: IPAT
1801 Woodfield Drive
Savoy, IL 61874
(217) 352-4739

7. The Delinquency/Illegal Behavior Domains

The National Youth Survey (NYS) (Elliott, Huizinga, and Ageton, 1985). This is a self-reported measure of delinquent and illegal behavior for adolescents. The 47 items were selected to be representative of the full range of official acts (except homicide) for which juveniles could be arrested. The NYS yields scores for the following three scales:

- "General Delinquency," a summary measure of all the delinquency items (lied about age, hitchhiked, bought liquor) except for a few "trivial" items
- "Index Offenses," except homicide and arson
- "Minor Delinquency," a 7-item scale including such minor offenses as being a runaway, or engaging in disorderly conduct or theft of less than $500.00.

The NYS measures the number of each type of offense committed during a 1-year period of the 47 delinquency items; it also includes 15 items on drug use. It requires 10 minutes for the average subject to complete.

Test items are available from the source listed below (either without cost or at nominal cost).

Access: Delbert S. Elliott, Ph.D.
Institute of Behavioral Science
University of Colorado
Boulder, CO 80309

Law Encounter Severity Scale (LESS) (Witherspoon, deValera, and Jenkins, 1973). The 38-item interview aims to assess the severity of an individual's encounter with the law enforcement system. Types of criminal offenses are surveyed, along with their frequency, severity, and consequences. Results from the interview can range from no encounter with illegal behavior to felonies that may lead to imprisonment for more than 1 year. Since each point on a 5-point scale of severity of illegal behavior is clearly defined in detail, the severity of each offense can be scored. The normative data were based on the post-release illegal behavior of 142 male felons in Alabama. Three judges independently ranked the illegal and law encounter behavior for severity of the type of offense, based on a 5-point scale of severity, and agreed in 90 percent of the cases.

The time required to administer is 20 minutes.

Test items are available at the following cost: instruction manual and 25 test forms, $25.00.

Access: The Behavior Science Press
P.O. Box BV
University of Alabama 35486
(205) 759-2089

Assessing Cocaine-Crack Use and Related Behaviors (Cocaine Use and Craving Scales)

Some of the assessment instruments recommended in this document, such as the Addiction Severity Index (ASI), were developed before the advent of the cocaine epidemic of recent years, and thus do not collect sufficient information regarding cocaine use. For example, they do not distinguish between smoking "crack," freebasing, intravenous (I.V.) drug use, and snorting cocaine. These methods of use have various serious consequences. Accordingly, the administration of a brief supplementary instrument is recommended for this specific purpose. Measures of cocaine use and cocaine craving have been developed by Gawin and Kleber (1984). These measures were more recently adapted by Carroll (1991).

The cocaine use instrument provides questions regarding the amount, method, and frequency of the client's cocaine use throughout his or her cocaine-using career. For example, for 1 month ago, 3 months ago, and 6 months ago, the client is asked how many grams of cocaine were used per week, the number of days used per week, and the usual method of administration. This instrument also includes questions regarding the areas of the client's life being disturbed by cocaine use.

The cocaine craving scale is a brief, 64-item self-report form that assesses the intensity of the client's current desire for cocaine on a 20-point scale ranging from "0" = "none at all" to "20" = "more than ever." The quality of the cocaine high experienced by the client and the amount of control over his or her urge for cocaine are also assessed.

The following two references may facilitate the effort to obtain copies of these two brief instruments: (1) Carroll, Rounsaville, and Gawin, (In Press.) A Comparative Trial of Psychotherapies for Ambulatory Cocaine Abusers: Relapse Prevention and Interpersonal Psychotherapy. Report to NIDA, Grant DA04299. Yale University; (2) Gawin, F.H. and Kleber, H.D. (1984). Cocaine abuse treatment. *Archives of General Psychiatry*, 44, pp. 903-909.

Assessing AIDS Risk Behavior

The instruments recommended in this document, other than the DATOS and Drug Abuse Treatment for AIDS-Risks Reduction (DATAR) instruments, do not include an assessment of AIDS risk behavior. Since applicants for drug abuse treatment who are I.V. drug users or who engage in certain types of sexual behavior are particularly at risk for the HIV infection and subsequently for AIDS, administration of an AIDS Risk Behavior questionnaire is recommended, as a supplement to one of the comprehensive alcohol or other drug problem screening instruments.

It is therefore recommended that those programs that do not plan to use the DATOS or DATAR instruments as their comprehensive intake screening procedure should use the "AIDS Risk Behavior" section of the DATOS Pretreatment Interview Form, or the "AIDS Risk Assessment" section of the DATAR, as a supplement to whatever comprehensive instrument they elect to use. This section of the DATOS includes 17 questions (items) for male clients and 13 questions (items) for female clients. The DATAR section includes a total of 41 items. The information required for gaining access to these two instruments can be found in the earlier section of this brochure, which describes the whole DATOS instrument.

For those clients for whom it appears, based on this brief survey of their risk behavior, that they may, in fact, be at risk for HIV infection, it is further recommended that a more thorough study of their risk behavior be conducted. The instrument that has been developed by NIDA for this later purpose for the National AIDS Research Project, is the Risk Behavior Assessment Questionnaire (RBA). The RBA sections are: "Sexual Activity," "Sex For Money/Drugs," sex-related diseases, health status, and I.V. and needle use behavior.

The RBA instrument is available from the Community Research Branch of NIDA (301-443-6720) 5600 Fishers Lane, Rockville, MD 20857.

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Part II
Instruments Reviewed by the Consensus Panel

1. Prototype Screening/Triage Form for Juvenile Detention Centers
2. CATOR (Comprehensive Assessment and Treatment Outcome Research)
3. CASI-A (Comprehensive Addiction Severity Index for Adolescents)
4. Teen Addiction Severity Index (T-ASI)
5. Sample Initial Health Screening Form - Short Form
   Sample Initial Health Screening Form - Long Form
6. Receiving Screening Form in Juvenile Detention and Confinement Facilities
7. Substance Abuse and Mental Health Assessment (SAMH 2)
8. Supervision Risk/Classification Instrument
9. Child Behavior Checklist for Ages 4 to 18 and
   Youth Self-Report for Ages 11 to 18
10. Revised Behavior Problem Checklist

1. Prototype Screening/Triage Form for Juvenile Detention Centers

Introduction

This instrument gathers information both objectively and subjectively in a number of areas to establish a juvenile's risk and service need in each information area. The information is based, in part, on the assessor's clinical judgment.

Developer

Richard Dembo, Ph.D. and Associates

Inquiries

Dr. Richard Dembo
Department of Criminology
University of South Florida
4202 E. Fowler Avenue
Tampa, FL 33620

Purpose

To assess a juvenile's overall risk and needs within juvenile detention facilities.

Type of Assessment

Face-to-face interview, with multiple choice and open-ended questions.

Life Areas and Problems Assessed

1. Admission and demographic
2. Education and employment
3. Home/living situation
4. Other personal information
5. AOD use
6. Sexual abuse history
7. Physical abuse history
8. Family history
9. Psychological/medical history
10. Mental health information

Reading Level

Not applicable

Credentials/ Training

Skilled interviewers whose training includes role playing, mock interviews, and rapport-building techniques.

Completion Time

45 minutes

Scoring Time

Scoring can take up to 20 minutes depending on problem areas identified.

General Commentary

This form, consisting of subjective and objective questions, collects demographic and reason-for-admission information on juvenile detainees, and obtains information on their status and functioning in 10 areas: 1. education/employment, 2. home/living situation, 3. other personal information (religious practice and gang membership), 4. alcohol/other drug use, 5. sexual abuse history, 6. physical abuse history, 7. family history, 8. psychological/medical history, 9. mental health information, and 10. legal history.

2. Comprehensive Assessment and Treatment Outcome Research (CATOR)

Introduction

CATOR includes an intake, history, and discharge form providing a combination of psychosocial history and key clinical information for use in screening and assessing adolescents involved in AOD treatment.

Developer

Norman G. Hoffman, Ph.D.
Assistant Professor of Psychiatry
University of Minnesota

Inquiries

Norman G. Hoffman, Ph.D.
Executive Director, CATOR
17 W. Exchange Street
St. Paul, MN 55102
(612) 221-3155

Purpose

CATOR's purpose is to provide a comprehensive psychosocial history as well as core clinical information of key variables at intake (and upon discharge) for adolescents involved in AOD treatment.

Type of Assessment

Face-to-face interview. Three separate forms, all multiple choice questions.

Life Areas and Problems Assessed.

The adolescent history form assesses: 1. School history; 2. Family substance abuse; 3. Physical/sexual abuse; 4. Lifetime stressors; 5. Past year stressors; 6. Religious involvement; 7. Substance use/social use patterns; 8. Employment; 9. Chemical dependency treatment history; 10. Emotional/psychological difficulties; 11. Substance-used frequency; 12. Age of onset of substance use; 13. Substance abuse symptoms; 14. Self-image; 15. Sexual activity; 16. Legal involvement.

The adolescent intake instrument assesses: 1. General background (includes referral sources); 2. Living arrangement; 3. Family/school; 4. Health payment resources; 5. Recent substance use; 6. Family income.

The adolescent discharge instrument assesses: 1. Level of substance use; 2. Symptoms of substance abuse; 3. Other problem areas; 4. Treatment status; 5. Discharge referrals/residential; 6. Discharge referrals/adjunct; 7. Family participation; 8. Substance abuse by family member; 9. Referrals for other family members.

Reading Level

Not applicable

Credentials/ Training

Basic training in interviewing techniques, especially in the area of adolescent substance abuse.

Completion Time

Different time for each of the three forms.

General Commentary

The CATOR is a baseline intake, psychosocial history, and discharge form used in screening and assessing adolescents involved in alcohol or other drug use treatment. In addition to obtaining psychological information, the intake form collects information on school history, family substance abuse, relationships with family members, physical/sexual abuse history, life stressors, religious involvement, substance use and treatment history, employment, medical care history, emotional and psychological difficulties, self-image, sexual activity, and legal involvement. The discharge form provides clinical information on level of substance use,

symptoms of substance abuse, treatment status, family participation in treatment and family substance use, and discharge referral recommendations.

3. Comprehensive Addiction Severity Index for Adolescents (CASI-A)

Introduction This instrument, designed to measure the severity of an adolescents' addiction, includes a cover sheet and a detailed assessment of each of seven areas within the young person's life.

Developer Kathleen Meyers

Inquiries Kathleen Meyers
Center for Studies of Addiction
8900 Chestnut Street
Philadelphia, PA 19104

Purpose To provide a comprehensive, in-depth assessment of the severity of an adolescent's AOD abuse.

Type of Assessment Includes objective face-to-face interview combined with urine drug screen results and observations from the assessor. (After each area assessed, there is space for comments as well as "confidence ratings": the degree to which the assessor believes the information may be distorted.)

Life Areas and Problems Assessed General screening overview (including urine drug screen results). In-depth assessment of seven areas: 1. Education; 2. Substance use; 3. Use of free time (time not spent in school—includes employment and sources for financial support); 4. Leisure activities; 5. Peer relationships (include sexual activity); 6. Family relationships; 7. Psychiatric status

Reading Level Not applicable. A staff person interviews the client.

Credentials/ Training Training in interviewing troubled youth with AOD problems

General Commentary The CASI-A is a general screening interview (including breathalyzer and urine drug test results), providing an in-depth assessment of the severity of an adolescent's alcohol/other drug use and related problems. Information is collected in 10 areas: 1) psychological, 2) significant life changes, 3) educational experiences and plans, 4) substance use, effects of use and treatment experiences, 5) use of free time—including employment and sources of financial support), 6) leisure activities, (7) peer relationships—including sexual activity and related diseases, 8) family history and relationships—including physical and sexual abuse, 9) legal history, and 10) psychiatric status—including treatment experiences. At the end of topic areas 3 through 10, space is provided for assessor's comments and "confidence ratings" (assessor's ratings regarding subject's misrepresentation or inability to understand the questions).

4. Teen Addiction Severity Index (T-ASI)

Introduction

This is a relatively brief assessment instrument developed for use when an adolescent is being admitted to inpatient care for AOD-related problems.

Developer

The Adolescent Drug Abuse and Psychiatric Treatment Program
Division of Child and Adolescent Psychiatry
Western Psychiatric Institute and Clinic
2811 O'Hara Street
Pittsburgh, PA 15213

Editors: Yifrah Kaminer, M.D.
Oscar Bukstein, M.D.
Ralph Tarter, Ph.D.

Inquiries

Either to Western Psychiatric Institute at above address and/or to:
Dr. Yifrah Kaminer, M.D.
Bradley Hospital
1011 Veteran's Memorial Parkway
East Providence, RI 02915

Purpose

The purpose of this instrument is to provide basic information on an adolescent prior to entry into inpatient care for AOD-related problems.

Type of Assessment

Objective face-to-face interview combined with opportunity for assessor to offer: comments, confidence ratings (indicating whether the information may be distorted), and severity ratings (indicating how severe the assessor believes is the need for treatment or counseling).

Life Areas and Problems Assessed

1. Chemical use; 2. School status; 3. Employment/support status; 4. Family relationships; 5. Peer/social relationships; 6. Legal status (involvement with criminal justice program); 7. Psychiatric status; 8. Contact list for additional information

The questions asked for each area are fewer in number than many other instruments described in this document.

Reading Level

Not applicable.

Credentials/ Training

Training in interviewing troubled youth with AOD problems.

General Commentary

The T-ASI is an interview instrument providing baseline information on adolescents prior to entering inpatient care for alcohol/other drug use problems. Information is collected in the following eight areas: 1) demographic, 2) chemical use—including consequences of use and treatment experiences, 3) school status, 4) employment/support status, 5) family relationships—including physical abuse and sexual abuse, 6) peer/social relationships, 7) legal status, and 8) psychiatric status—including treatment experiences. At the end of topic areas 2 through 8, space is provided for assessor's comments, a problem severity rating, and "confidence ratings" (assessor's ratings regarding subject's misrepresentation or inability to understand the questions).

5. Sample Initial Health Screening Form - Short Form
Sample Initial Health Screening Form - Long Form

Introduction These forms are part of the "Standards for Health Services in Juvenile Detention and Confinement Facilities" and are intended to serve as minimum requirement guidelines.

Developer National Commission on Correctional Health Care

Inquiries National Commission on Correctional Health Care
2105 North Southport
Chicago, IL 60614-4017
(312) 528-0818

Purpose The purpose of both the short and the long screening form is to provide a standard for minimum requirements concerning juveniles in detention and confinement facilities. The short form is to be used when a full health assessment is likely to be performed within the first 48 hours of a juvenile admission and is designed to flag potential emergencies, such as suicide attempts. The long form is to be used when a full health assessment is not likely within the first 48 hours, providing more in-depth information that may be useful to the staff until a full assessment can be done.

Type of Assessment Short form: Seven out of 12 questions require simple documentation on the part of the examiner. The remaining five questions request basic information from the youth.

Long form: Requires examiner to note both simple observations and response to some basic questions.

Life Areas and Problems Assessed Short Form: Asks basic questions about youth's medical and mental conditions, attempting to identify warning signals for immediate, urgent problems such as suicidal behavior.

Long Form: 1. Physical and mental condition, including medical and immunization history; 2. Substance use

Reading Level Not applicable.

Credentials/ Training Some medical training helpful along with training in interviewing and observation techniques.

General Commentary The receiving screening form, short and long screening forms, reflect standards for minimum requirements concerning health services for juveniles in detention and confinement facilities. The receiving screening form, completed by the intake officer or physician, includes his/her visual opinion about the newly admitted youth in a number of areas (for example, visible signs of trauma or illness, appears under the influence of alcohol or other drugs, in AOD withdrawal, juvenile's behavior suggests risk of suicide or assault to staff or other juveniles) and a brief questionnaire administered by the intake officer to the juvenile (e.g., currently taking medication for diabetes, heart disease, asthma; requires a special diet;

has epilepsy, hepatitis, or painful dental condition). The short form is to be used when a full health assessment is likely to be performed within the first 48 hours of an admission; it is designed to flag potential emergencies, such as injury, infection, being under the influence of alcohol/other drug use or experiencing AOD withdrawal, appearing despondent, or previous suicide attempts. The long form is to be used when a full health assessment is not likely to be performed within the first 48 hours of a juvenile's admission. It provides comprehensive information for use by health care staff until a full health appraisal of the youth can be completed. The long form includes: 1) an examiner's observations of the youth in a variety of areas (for example, evidence of trauma, infection or illness; being under the influence of alcohol/other drugs or undergoing withdrawal; behavior suggesting risk of suicide or assault), and 2) an examiner-administered questionnaire to the juvenile probing his/her medical condition, use of alcohol, use of "street" drugs, immunization history, and (for females) pregnancy and gynecological problems.

6. Receiving Screening Form in Juvenile Detention and Confinement Facilities

Introduction This form is part of the *Standards for Health Services in Juvenile Detention and Confinement Facilities.*

Developer National Commission on Correctional Health Care

Inquiries National Commission on Correctional Health Care
2105 North Southport
Chicago, IL 60614-4017
(312) 528-0818

Purpose To provide the intake officer in a juvenile correctional facility with a standard screening form to use upon the youth's entry.

Type of Assessment The screening form is in two parts: 1) the intake officer's visual opinion regarding the youth and 2) questionnaire asked by intake officer to juvenile.

Life Areas and Problems Assessed Medical condition, history and problems; signs of AOD abuse; and visual behavior.

Reading Level Not applicable

Credentials/ Training Minimal training in medical interviewing would be helpful.

Scoring Procedures This instrument is not scored. Intake officer is asked to provide final remarks and the form is entered into the youth's medical record.

Scoring Time Not applicable (see above).

General Commentary The receiving screening form, short and long screening forms, reflect standards for minimum requirements concerning health services for juveniles in detention and confinement facilities. The receiving screening form, completed by the intake officer or physician, includes his/her visual opinion about the newly admitted youth in a number of areas (for example, visible signs of trauma or illness, appears under the influence of alcohol or other

drugs, in AOD withdrawal, juvenile's behavior suggests risk of suicide or assault to staff or other juveniles) and a brief questionnaire administered by the intake officer to the juvenile (e.g., currently taking medication for diabetes, heart disease, asthma; requires a special diet; has epilepsy, hepatitis, or painful dental condition). The short form is to be used when a full health assessment is likely to be performed within the first 48 hours of an admission; it is designed to flag potential emergencies, such as injury, infection, being under the influence of alcohol/other drug use or experiencing AOD withdrawal, appearing despondent or previous suicide attempts. The long form is to be used when a full health assessment is not likely to be performed within the first 48 hours of a juvenile's admission. It provides comprehensive information for use by health care staff until a full health appraisal of the youth can be completed. The long form includes: 1) an examiner's observations of the youth in a variety of areas (for example, evidence of trauma, infection or illness; being under the influence of alcohol/other drugs or undergoing withdrawal; behavior suggesting risk of suicide or assault), and 2) an examiner-administered questionnaire to the juvenile probing his/her medical condition, use of alcohol, use of "street" drugs, immunization history, and (for females) pregnancy and gynecological problems.

7. Substance Abuse and Mental Health Assessment (SAMH 2)

Introduction

This assessment instrument is used throughout the State of Florida within agencies treating youth with AOD problems and can be used as a model for other States.

Developer

Florida Department of Health and Rehabilitative Services

Inquiries

Florida Department of Health and Rehabilitative Services
Alcohol, Drug, Mental Health Office
W.T. Edwards Building, 4th Floor
4000 West Dr. Martin Luther King Junior Blvd.
Tampa, FL 33614
(813) 871-7660
Attention: Gail Potter, Contract Manger for Substance Abuse

Purpose

The purpose of this instrument is for the State to provide a standard comprehensive assessment form to be used by agencies throughout the State who offer some type of outpatient/community-based AOD services to youth.

Type of Assessment

Part I is a questionnaire for the assessor to ask the youth. Part II is to be filled out by the assessor based on visible observations of the youth and prior documents and reports. Part III is the assessor's summary of findings, comments, and recommendations.

Life Areas and Problems Assessed

Part I asks brief questions regarding the following areas: identifying data, legal status, educational/vocational information, home/living situation, other personal information (such as gang affiliation and thrill-seeking activity). A much more extensive segment on substance abuse history, family history, and psychological medical information concludes Part I.

Part II assesses the interviewer's observations about the youth's mental health and to summarize reports and documented evidence regarding physical and sexual abuse.

Reading Level

Not applicable.

Credentials/

Parts I and II require basic training in interviewing techniques regarding youth with AOD

Training	problems. The final segment requires the assessor to provide recommendations for referral and/or further treatment, necessitating adequate training regarding community resources and ability to evaluate the agency's capacity to meet the youth's needs.
General Commentary	This form contains many items included in the Prototype Screening/Triage Form and probes functioning in many of the domains tapped by the Prototype form. Limited information is gathered on youths' sexual victimization and physical abuse histories. The SAMH 2 form serves as a psychosocial assessment instrument for youths in the State of Florida entering the juvenile justice system and alcohol/other drug abuse programs. Clinical evaluation of the information results in recommendations for further evaluation or program placement.

8. Supervision Risk/Classification Instrument

Introduction	This instrument is used throughout Florida to assess the risk and needs of juveniles involved with the criminal justice system.
Developer	Florida Department of Health and Rehabilitative Services
Inquiries	Florida Department of Health and Rehabilitative Services Alcohol, Drug, Mental Health Program Office W.T. Edwards Building, 4th Floor 4000 West Dr. Martin Luther King Junior Blvd. Tampa, FL 33614 Attention: Gail Potter, Contract Manager for Substance Abuse (813) 871-7660
Purpose	This instrument is designed for use within government agencies to classify the risks, service needs, and appropriate levels of commitment for youth involved with the criminal justice system. Instrument also includes an attachment used to reclassify youth on community control or furlough supervision. Reclassification is to be done every 60 days or whenever there are significant changes in a youth's supervision (for example, additional law violations, etc.). Instrument is intended to be filled out by case managers.
Type of Assessment	This assessment is completed by the case manager through the rating of risks within particular categories. There is no need for the youth to be present when the instrument is filled out. However, the instrument requires the case manager to be knowledgeable about the youth's situation.
Life Areas and Problems Assessed	Section I—Identifying Data; Section II—Risk Assessment (most serious illegal offense, prior history of illegal offenses, other factors); Section III—Needs Assessment (assessing the needs in regard to family relationships, parental dysfunction, peer relationships, significant adult relationships, education, employment, developmental disabilities, health and hygiene, mental health, and substance abuse. Notes "mitigating factors" (for example, successful completion of program) and "aggravating factors" (for example, youth has a felony violation), which should be taken into account when deciding the youth's appropriate level of commitment.
Reading Level	Not applicable.
Credentials/ Training	The assessor needs minimal training in learning how to score the instrument and evaluating the youth's behavior and/or records. Does not require interviewing skills.
Scoring	Each response to be made by the assessor is designated with a point. The points for each

Procedures response appear directly on the form (for example: One violent felony offense gets seventeen points, one prior misdemeanor gets one point). The total risk score is added up, as is the total needs score. The scores are then used to make placement recommendations regarding the youth's status.

General Commentary This instrument is to be completed by the case manager of a youth involved in the juvenile justice system. It is designed for use in recommending a level of program structure and commitment for the youth. Reclassification is to be completed every 60 days or whenever there is a significant change in the youth's supervision status (for example, a new law violation). Information included in the form covers the following topic areas: 1) identifying data of youth and case manager, 2) risk assessment (instant offense, prior legal history, other scoring factors [for example, previous technical violations of supervision, history of escape/absconding, substance abuse involvement]), consideration of mitigating factors [for example, no new referrals, successful program completion] and aggravating factors [youth has a felony law violation, returned to supervision status from absconder status], and 3) needs assessment (family relationships, parental dysfunctions [including a history of abuse/neglect], peer relationships, significant adult relationships, educational problems, employment experiences, developmental disabilities, physical health and hygiene, mental health, and substance abuse).

9. Child Behavior Checklist for Ages 4 to 18 and Youth Self-Report for Ages 11 to 18

Introduction These instruments are checklists to be filled out by a young person's parent/guardian or the young person him/herself designed to flag many potential problems, including AOD use.

Developer T.M. Achenbach

Inquiries T.M. Achenbach
University of Vermont
1 S. Prospect Street
Burlington, VT

Purpose The purpose of these instruments is for the young person's parent or guardian or the young person directly to check off various types of behaviors the youth engages in which can then be assessed by a professional.

Type of Assessment These instruments are questionnaires to be filled out by parent, guardian, or the young person. Most of the questions are simple multiple choice questions. There is some space available for the parent or youth to note concerns and successes.

Life Areas and Problems Assessed Checklists include: the youth's activities (hobbies, sports, jobs, chores), peer relationships, academic performance, medical or mental handicap. True/false segment of the checklist asks a variety of questions about behaviors related to mental health (for example, whether the youth acts or feels isolated, restless, etc.).

Reading Level Checklists can easily be filled out by someone at the eighth-grade level or below.

Credentials/ Training The parent or youth filling out the checklists needs no training other than knowledge of their child's or their own behavior. However, checklists must be evaluated by someone with an extensive background in child psychology.

Scoring Procedures Scoring procedures are not written on the checklists. The person reviewing the checklists is to evaluate overall responses.

General Commentary	The Child Behavior Checklists identify problems in several areas, including AOD use, which can be assessed by a professional for further followup. The checklist probes the following areas: 1) youth activities (hobbies, sports, organizations/clubs, jobs/chores), 2) social relationships (friends, siblings, parents), 3) academic performance, 4) possession of an illness, physical or mental handicap, and 5) a list of 112 specific questions probing behaviors/problems in the past 6 months related to physical and mental health (for example, being restless, disobedient, aggressive, withdrawn, stealing, having allergies, headaches, problems with eyes, the use of alcohol or other drugs for nonmedical purposes).

10. Revised Behavior Problem Checklist

Introduction	This is a simple checklist that can be used by anyone.
Developer	Herbert C. Quay, Ph.D. University of Miami and Donald R. Peterson, Ph.D. Rutgers University Developed in 1983
Purpose	This instrument offers a simple checklist of potential problem behaviors to be filled out by parent, guardian, or anyone who is knowledgeable about the youth.
Type of Assessment	A two-page checklist of problem behaviors. The person filling the form is to indicate the extent to which the behavior is mild, severe, etc.
Life Areas and Problems Assessed	Checklist includes behaviors indicating potential problems with self-esteem, peer and family relationships, and school performance.
Reading Level	Eighth grade or below.
Credentials/ Training	No training necessary.
Completion Time	Five to 10 minutes at most.
General Commentary	This form is a simple checklist, to be completed by a parent, guardian, or anyone who is knowledgeable about the youth, regarding his/her potential problem behaviors. The instrument collects information in six problem areas: 1) conduct disorder, 2) socialized aggression, 3) attention problems, 4) anxiety or withdrawal, 5) psychotic behavior, and 6) motor excess.

Appendix B—Monograph: Drug Testing Of Juvenile Detainees

ACA IBH

Monograph

Drug Testing of Juvenile Detainees

August 1, 1991

Prepared Under Grant No. **89-JN-CX-K004**
from the Office of Juvenile Justice and Delinquency Prevention,
Office of Justice Programs, U.S. Department of Justice

Introduction

The American Correctional Association and the Institute for Behavior and Health Inc., funded by a grant from the Office of Juvenile Justice and Delinquency Prevention (OJJDP), collaborated on a project to determine the status of drug testing of juvenile detainees and to develop prototype elements of a drug testing program, related policies and procedures and a training curriculum.

Juveniles at high risk for drug use are also at high risk for delinquent behavior, which often leads to arrest and detention. Information about recent drug use helps detention staff make appropriate case-management decisions, which may include drug treatment. Urine drug testing is the most reliable way to detect recent drug use.

In conjunction with the project, written and telephone surveys gathered information from juvenile detention programs throughout the United States. Staff members from ACA and IBH conducted site visits to detention facilities with drug testing programs. Subsequently, the best program components were identified, and a prototype drug testing program was developed. IBH and ACA drafted guidelines, as well as related policies and procedures and a training curriculum, to set up a drug testing prototype in a juvenile detention program.

Establishing recent drug use is not a substitute for educational, medical, psychological, or other rehabilitative care. Detection is a necessary precondition for these strategies to work since drug use exacerbates all other physical, mental, and emotional problems.

Several studies have revealed a powerful association between drug use and delinquency. Often, peer behaviors strongly influence drug use and other risky adolescent behaviors (c.f., White et al., 1985; Robinson et al., 1987; Huizinga & Elliott, 1981). Most studies have found that increased drug use is associated with increased delinquent behavior.

The Drug Use Forecasting (DUF) surveys conducted by the National Institute of Justice have been extended to include males detained at juvenile facilities in 11 cities in the United States. DUF data is collected through voluntary and anonymous urine drug testing of arrestees. Drug use was detected in 10% (Kansas City) to 31% (Los Angeles) of the juveniles tested in 1990. Marijuana use was most frequently detected in eight cities, marijuana and cocaine were detected almost equally in one city, and positive tests for cocaine were highest in Washington, D.C. and Cleveland. In addition, multiple drug use was detected at all sites (DUF, in press).

Studies comparing the drug use histories of juveniles involved in the justice system with juveniles in the general population have yielded striking results. For example, the Colorado Division of Youth Services conducted a survey of juveniles admitted to five corrections centers and compared the results with 12- to 17-year-old juveniles in the 1982 National Household Survey on Drug Abuse sponsored by the National Institute on Drug Abuse (NIDA). Ninety-five percent of the Colorado juveniles reported having used marijuana and alcohol. Over half had used hallucinogens, stimulants, cocaine, and inhalants, and over 30% had used painkillers, sedatives or tranquilizers non-medically. Compared to the 1982 NIDA sample, juveniles in contact with the juvenile justice system were almost three times more likely to have used illegal drugs, and they were twice as likely to have used alcohol (Colorado Division of Youth Services, 1985). Dembo and his colleagues (1988) reached similar conclusions comparing juveniles between the ages of 10 and 18 in a Florida detention center with those in the 1985 NIDA National Household Survey. In this sample, 72% were male. The detained juveniles reported dramatically greater drug use: marijuana use was 70% for detained juveniles compared to 24% in the NIDA sample, and the rates for lifetime cocaine use were 37% and 5%, respectively.

One program, where juveniles are required to pay the cost of testing when the results are positive, uses admission of drug use instead of testing. One administrator noted that on-site testing serves as a "lie detector" because juveniles know results will be available quickly. When faced with the certainty that the equipment will verify drug use, juveniles often will acknowledge recent drug use voluntarily, reducing or eliminating the cost of a drug test.

Prevention of drug use and related delinquent activity is the goal of all juvenile drug testing. Achieving abstinence from drug and alcohol use is the primary goal of urine drug testing for juveniles who become involved in the juvenile justice system. The legal, emotional, and social handicaps of continued drug and alcohol use practically ensure future problems for these high-risk juveniles. Urine drug testing helps make juveniles accountable for their actions, minimizing denial and emphasizing the importance of maintaining a drug-free lifestyle.

A summary literature review was prepared based on the existing juvenile drug testing information. This literature review served as the background for an expert workshop. Thirty experts from juvenile detention, drug testing, and academic research were brought together to discuss and develop the key elements of a model drug testing program for juveniles in detention. The parameters of the model included the caveat that testing be conducted in the context of other needs, and the reminder that detention is only a piece of the larger system of juvenile justice. The group unanimously agreed that the test results be used for case management purposes only.

Juvenile Detention Center Survey

A written questionnaire was prepared and sent to over 500 juvenile detention facilities across the United States. Forty-eight percent, or 237 questionnaires, some with written guidelines and/or policies and procedures attached, were returned and analyzed. Sixty-three centers were identified as having some type of drug testing program.

Prerequisites for testing, size, and extent of the program yielded 35 juvenile detention sites that were contacted by telephone. The telephone interview clarified information on the original

The visited programs test for a variety of drugs on the initial screen. All the programs test juveniles for marijuana and cocaine; all but one program tests for alcohol use either routinely or upon suspicion of use. Other drugs are added to the screen if a drug becomes popular locally or if a laboratory contract specifies a particular drug profile. Cut-off levels usually correspond to NIDA recommendations or to those determined by the manufacturers of on-site equipment.

Most of the detention programs reviewed use positive test results to design case-management plans, including medical intervention and treatment referral. Some programs keep detailed records and monitor community drug use trends, although the extent of record keeping varies among facilities.

Visited detention programs were equally divided between those who did on-site testing and those that used off-site laboratories. All detention sites that routinely test each detainee agree that urine drug testing is a significant asset to the program.

Administrative and staff concerns included budgetary constraints that prevent testing programs from becoming an integral part of the detention process and a lack of education about drugs and testing procedures, which leads to fears about handling urine because of the risk of AIDS transmission. Legal issues surrounding drug testing concern staff in centers where positive results can lead to legal action. An additional concern was expressed about the strain drug testing can place on staff schedules filled with other duties. Administrators expressed interest in enhancing the testing programs by expanding testing to include all detainees, adding more drugs to the screen, reducing turn-around time, increasing budgetary support, and improving staff support and education.

Several programs currently use testing to track community drug use trends. A few sites anticipate entering test results on a computer for analysis. In some detention programs, the number of drug positives has dropped substantially since the initiation of testing.

Although drug use among juveniles is recognized as a major problem, most detention facilities in the country do not have drug testing as part of their detention programs.

To date, few states have enacted legislation authorizing juvenile testing for drugs of abuse. For that matter, it has only been within the past few years that some states and the federal government have amended statutes authorizing jurisdictions to test adult arrestees. Aside from legislative authorization, authority for testing may exist in Court Rules, departmental decrees, or specific judicial or probation orders. The American Probation and Parole Association, in drug testing guidelines for adult probationers and parolees published July 1991, recommends that "drug testing should be authorized by state law instead of being merely a condition imposed by the judge or parole board."[2]

Despite the lack of specific legislative authorization, many juvenile justice systems are using drug testing at some level. Some use drug testing as part of a routine assessment procedure after adjudication for identifying appropriate candidates for treatment programs. Several jurisdictions conduct testing within secure institutions. With or without specific authorization, many practitioners view drug testing as a tool well within the traditional framework of the juvenile justice system.

The District of Columbia has an extensive juvenile drug testing program. Although legal cultures and practices vary from place to place, the experience of the District is useful in that it illustrates how local officials, applying traditional principles of the juvenile justice system, developed a legal basis for implementing comprehensive juvenile drug testing. The elements of the program include testing juveniles immediately after arrest; as a condition of release pending adjudication; and as a condition of probation after adjudication. The tests are conducted by the D.C. Pretrial Services Agency, which operates a drug testing laboratory located in the courthouse. Drug test results become part of the juvenile's "social record" and are subject to strict confidentiality laws.

As with other locations, the District of Columbia Code provides no specific statutory authorization for drug testing, or for using drug test results in juvenile proceedings. However, the statute was viewed as sufficiently broad to encompass drug testing. The D.C. statute is quite similar to most state statutes. Although juveniles now have many due process rights, the system still reflects the paternal orientation that has been the hallmark of the system for the past 90 years. The accused juvenile is a "respondent," not a "defendant." Charges are brought by a "petition" and the truth of the allegations

[2] Guideline 4-3, "Authority to Test," Drug Testing Guidelines and Practices for Adult Probation and Parole Agencies," July, 1991. The Commentary to this guideline goes on to state that "although courts have generally considered drug testing imposed by the judge... without legislative authorization as valid, the passage of such legislation ensures a more successful defense against potential legal challenges." (page 13)

Taken together, the philosophy of the juvenile justice system, the factors to be considered at intake, and the well-recognized role of the Court to serve in a semi-parental capacity "in the best interests of the child" all support the view that drug testing is appropriate. This belief is reflected in a "Memorandum of Understanding" setting forth the goals and procedures of juvenile drug testing, and in an order issued by the Chief Judge directing the Pretrial Services Agency to "perform drug tests on and monitor compliance with Court ordered conditions by juvenile offenders..."

Whether the experience of the District of Columbia is applicable to other jurisdictions is a matter for those jurisdictions to determine for themselves. Two final points bear noting. First, after almost five years of continuous operation in which almost every juvenile is tested at intake, no legal or constitutional challenges have been filed. Second, the legal framework for the juvenile justice system in Washington, D.C. is quite similar in philosophy and substance to that of most states. Although specific legislative authorization for juvenile drug testing is clearly preferable, existing authority is probably sufficient to conduct post-adjudication testing. Pre-adjudication testing should be approached cautiously. However, the positive experience of the District of Columbia may offer some guidance and encouragement to practitioners in other states.

Operational Issues

Operational issues for urine drug testing include developing policies and procedures, determining types of equipment, staffing, location of equipment, and related issues. Some issues are simple; others are technical. A simple issue at one detention center may be a complex issue at another. The following paragraphs present common operational issues and include recommendations based on site visits of existing programs.

Urine collection should always be observed since samples can be altered easily. A staff member of the same sex monitors while the juvenile disrobes, showers, and provides a urine sample. Urine samples collected while the juvenile is unclothed present few opportunities for adulterating the sample

Table One

Commonly Used Technologies for Detecting Drug Abuse in Urine

TLC (thin-layer chromatology)	The TLC process is based on concentration of the urine sample, separation of compounds on a thin layer of silica, and interaction with chemical compounds that produce characteristic color reactions. These color reactions are evaluated by a trained laboratory technician to determine the presence of a drug.
Immunoassay Tests:	Immunoassay tests are new, more sensitive, higher-technology tests, which depend on an immunologic chemical reaction involving antibodies and antigens. Antibodies are developed in animals to react with a specific drug. A label or tag is then chemically attached to a sample of the drug sought. The tagged drug, the untagged drug in the urine specimen, and the antibody are then mixed together during the immunoassay test. Each of the immunoassays detects a drug using a different process, explained below.
EIA (enzyme immunoassay)	EIA tests urine by measuring color change with a device called a spectrophotometer. Gives qualitative results quickly, but does not produce quantitative results.
RIA (radio-immunoassay)	Uses radioactive tags to identify drugs in urine. This method produces qualitative and quantitative results.
FPIA (fluorescence polarization immunoassay)	Uses fluorescent tags, which are counted by a computer-driven system to determine drugs in urine. This method gives both semiquanitative and qualitative results.
GC/MS (gas chromatography/mass spectrometry)	Most frequently used as confirmation test, this method heats the urine sample until it vaporizes and the drug metabolites are separated. These components are passed through a capillary column. Of the many ways used to detect drugs, mass spectrometry is the most accurate. Gas chromatography used with mass spectrometry is known as GC/MS and is the gold standard against which all other detection methods are compared.

enzyme technique. Hair testing has a longer detection window than urine testing. A one-and-a-half inch hair sample shows drug use over a period of three months compared to a one- to five-day detection window for urine testing. Some people consider hair testing to be less invasive than urine testing. It also has the advantage of easy retesting. Currently, however, the turn-around time is longer than other techniques. Hair testing technology is more costly per sample than urine testing and is used less often.

Breathalizer devices detect recent alcohol use by measuring blood alcohol level. Alcohol use is difficult to assess because of technological limitations and the metabolic properties of alcohol that make detection difficult unless testing occurs within a few hours of alcohol use.

New single test kits using saliva have recently become available to test for alcohol use. Advancement in the science of drug testing will add more technologies in the future, and some of them may be less intrusive and more efficient.

On-Site and Off-Site Testing

On- and off-site drug testing options are available to detention programs. Turn-around time for test results, size of the facility, and budgetary or staff constraints determine which testing strategy is preferable. One does not automatically preclude the other. For example, a program might want to do most of its testing on-site and send only positive samples to a laboratory for confirmation. Conversely, a program may want to have all testing performed by a service laboratory and reserve on-site testing for emergency or quick turn-around tests. Generally, high-volume urine testing requires laboratory testing.

The detention programs visited use a variety of laboratories for off-site testing including a health department facility, a probation department laboratory and a coroner's laboratory. Commercial laboratories are also suitable for testing. Most laboratories provide mailing services for clients who are located outside a metropolitan area. Laboratories usually supply all materials needed to collect,

Cut-off Levels and Limits of Detection

Urine testing program personnel need to be familiar with the detection limits following drug use, which are described in Table Two. As seen in the following table, the periods for successful detection differ from substance to substance. This information is essential for program counselors to evaluate accurately an individual's prior and present drug use. Knowing the duration of the detection period of individual drugs also helps to determine the frequency of random testing most appropriate for each client.

Table Two
Approximate Limits of Detection of Drug Use by Urinalysis*

Drug	Duration of Detectability
Alcohol	12 hours or less
Amphetamines	48 hours
Barbiturates	1 to 7 days
Cannabinoids (marijuana, hashish)	3 to 27 days
Cocaine (coke, crack)	2 to 3 days
Lysergic Acid Diethylamide (LSD)	1 to 3 days
Opiates (heroin, morphine)	48 hours
Phencyclidine (PCP)	8 days
Synthetic Narcotics (China White, Fentanyl)	1 to 5 days

*This chart adapted from the Journal of the American Medical Association, 257 (22) p. 3112.

Conclusions and Recommendations

Significant intervention must take place to prevent repeat offenses and to prevent the juvenile from graduating to the adult criminal justice system. Providing a system of drug use detection and intervention may be an important step in preventing recidivism.

Juvenile detention centers can detect drug use by urine testing detainees during the intake process. The results of urine tests offer a valuable tool for assessing the needs of detained juveniles. Knowledge of drug use allows appropriate intervention and treatment options to be incorporated into case-management plans.

Juvenile detention facilities with drug testing programs find the results useful for individualizing the care of detainees, making appropriate plans for their entry back into the community, and establishing drug use patterns for the community. Drug use is viewed as an important component in the overall medical and psychological profile of each juvenile.

Initiating a urine drug testing program in a detention facility is a challenging yet rewarding enterprise. As urine testing has become more common in juvenile justice systems, many problems have been solved, and many questions have been answered. The issues discussed in this document are important considerations in initiating a drug testing program. A drug testing program provides valuable information about the detainee population for the best possible prognosis for re-entry into the community.

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Appendix C—Psychoactive Substance Use Disorders*

*It is important to note that the DSM-III-R was developed by the American Psychiatric Association on the basis of clinical experience with adults. It should be used primarily as a frame of reference in addressing adolescent AOD problems.

Psychoactive Substance Use Disorders

In our society, use of certain substances to modify mood or behavior under certain circumstances is generally regarded as normal and appropriate. Such use includes recreational drinking of alcohol, in which a majority of adult Americans participate, and the use of caffeine, in the form of coffee or tea, as a stimulant. On the other hand, there are wide cultural variations. In some groups even the recreational use of alcohol is frowned upon, whereas in other groups the use of various illegal substances for mood-altering effects has become widely accepted. In addition, certain psychoactive substances are used medically for the alleviation of pain, relief of tension, or to suppress appetite.

This diagnostic class deals with symptoms and maladaptive behavioral changes associated with more or less regular use of psychoactive substances that affect the central nervous system. These behavioral changes would be viewed as extremely undesirable in almost all cultures. Examples include continued use of the psychoactive substance despite the presence of a persistent or recurrent social, occupational, psychological, or physical problem that the person knows may be exacerbated by that use and the development of serious withdrawal symptoms following cessation of or reduction in use of a psychoactive substance. These conditions are here conceptualized as mental disorders, and are therefore to be distinguished from nonpathological psychoactive substance use, such as the moderate imbibing of alcohol or the use of certain substances for appropriate medical purposes.

The disorders classified in this section are to be distinguished from Psychoactive Substance-induced Organic Mental Disorders because Psychoactive Substance Use Disorders refer to the maladaptive behavior associated with more or less regular use of the substances whereas Psychoactive Substance-induced Organic Mental Disorders describe the direct acute or chronic effects of such substances on the central nervous system. Almost invariably, people who have a Psychoactive Substance Use Disorder will also have a Psychoactive Substance-induced Organic Mental Disorder, such as Intoxication or Withdrawal.

For all classes of psychoactive substances, pathological use is categorized as either Psychoactive Substance Dependence or the residual diagnosis of Psychoactive Substance Abuse. For a discussion of the role of toxicologic analysis of body fluids in the diagnosis of Psychoactive Substance Use Disorders, see p. 125.

PSYCHOACTIVE SUBSTANCE DEPENDENCE

The essential feature of this disorder is a cluster of cognitive, behavioral, and physiologic symptoms that indicate that the person has impaired control of psychoactive substance use and continues use of the substance despite adverse consequences. The symptoms of the dependence syndrome include, but are not limited to, the physiologic symptoms of tolerance and withdrawal (as in DSM-III). Some people with physiologic tolerance and withdrawal may not have the dependence syndrome as defined here. For example, many surgical patients develop a tolerance to prescribed opioids and experience withdrawal symptoms without showing any signs of impaired control of their use of opioids. Conversely, other people may show signs of severely impaired control of psychoactive substance use (e.g., of cannabis) without clear signs of physiologic tolerance or withdrawal. Some heavy coffee-drinkers are physiologically dependent on caffeine and exhibit both tolerance and withdrawal. However, such use is generally not associated with dependence as defined here, and few, if any, of these people have difficulty switching to decaffeinated coffee or coffee substitutes. Therefore, Caffeine Dependence is not included in this classification of mental disorders. In contrast, Caffeine Intoxication is often clinically significant, and therefore is included (as a Psychoactive Substance-induced Organic Mental Disorder).

The symptoms of the dependence syndrome are the same across all categories of psychoactive substances, but for some classes some of the symptoms are less salient, and in a few instances do not apply (e.g., withdrawal symptoms do not occur in Hallucinogen Dependence). At least three of the nine characteristic symptoms of dependence are necessary to make the diagnosis. In addition, the diagnosis of the dependence syndrome requires that some symptoms of the disturbance have persisted for at least one month, or have occurred repeatedly over a longer period of time, as in binge drinking.

Dependence as defined here is conceptualized as having different degrees of severity, and guidelines for mild, moderate, and severe dependence and dependence in partial or full remission are provided.

Symptoms of Dependence

The following are the characteristic symptoms of dependence. It should be noted that not all nine symptoms must be present for the diagnosis of Dependence, and for some classes of psychoactive substances, certain of these symptoms do not apply.

1. The person finds that when he or she actually takes the psychoactive substance, it is often in larger amounts or over a longer period than originally intended. For example, the person may decide to take only one drink of alcohol, but after taking this first drink, continues to drink until severely intoxicated.

2. The person recognizes that the substance use is excessive, and has attempted to reduce or control it, but has been unable to do so (as long as the substance is available). In other instances the person may want to reduce or control his or her substance use, but has never actually made an effort to do so.

3. A great deal of time is spent in activities necessary to procure the substance (including theft), taking it, or recovering from its effects. In mild cases the person may spend several hours a day taking the substance, but continue to be involved in other activities. In severe cases, virtually all of the user's daily activities revolve around obtaining, using, and recuperating from the effects of the substance.

4. The person may suffer intoxication or withdrawal symptoms when he or she is expected to fulfill major role obligations (work, school, homemaking). For example, the person may be intoxicated when working outside the home or when expected to take

care of his or her children. In addition, the person may be intoxicated or have withdrawal symptoms in situations in which substance use is physically hazardous, such as driving a car or operating machinery.

5. Important social, occupational, or recreational activities are given up or reduced because of substance use. The person may withdraw from family activities and hobbies in order to spend more time with substance-using friends, or to use the substance in private.

6. With heavy and prolonged substance use, a variety of social, psychological, and physical problems occur, and are exacerbated by continued use of the substance. Despite having one or more of these problems (and recognizing that use of the substance causes or exacerbates them), the person continues to use the substance.

7. Significant tolerance, a markedly diminished effect with continued use of the same amount of the substance, occurs. The person will then take greatly increased amounts of the substance in order to achieve intoxication or the desired effect. This is distinguished from the marked personal differences in initial sensitivity to the effects of a particular substance.

The degree to which tolerance develops varies greatly across classes of substances. Many cigarette-smokers consume more than 20 cigarettes a day, an amount that would have produced definite symptoms of toxicity when they first started smoking. Many heavy users of cannabis are not aware of tolerance to it, although tolerance has been demonstrated in some people. Whether there is tolerance to phencyclidine (PCP) and related substances is unclear. Heavy users of alcohol at the peak of their tolerance can consume only about 50% more than they originally needed in order to experience the effects of intoxication. In contrast, heavy users of opioids often increase the amount of opioids consumed to tenfold the amount they originally used—an amount that would be lethal to a nonuser. When the psychoactive substance used is illegal and perhaps mixed with various diluents or with other substances, tolerance may be difficult to determine.

8. With continued use, characteristic withdrawal symptoms develop when the person stops or reduces intake of the substance. The withdrawal symptoms vary greatly across classes of substances. Marked and generally easily measured physiologic signs of withdrawal are common with alcohol, opioids, sedatives, hypnotics, and anxiolytics. Such signs are less obvious with amphetamines, cocaine, nicotine, and cannabis, but intense subjective symptoms can occur upon withdrawal from heavy use of these substances. No significant withdrawal is seen even after repeated use of hallucinogens; withdrawal from PCP and related substances has not yet been described in humans, although it has been demonstrated in animals. (See the specific withdrawal syndromes in Psychoactive Substance-induced Organic Mental Disorders.)

9. After developing unpleasant withdrawal symptoms, the person begins taking the substance in order to relieve or avoid those symptoms. This typically involves using the substance throughout the day, beginning soon after awakening. This symptom is generally not present with cannabis, hallucinogens, and PCP.

Diagnostic criteria for Psychoactive Substance Dependence

A. At least three of the following:

(1) substance often taken in larger amounts or over a longer period than the person intended

(continued)

Diagnostic criteria for Psychoactive Substance Dependence continued

(2) persistent desire or one or more unsuccessful efforts to cut down or control substance use
(3) a great deal of time spent in activities necessary to get the substance (e.g., theft), taking the substance (e.g., chain smoking), or recovering from its effects
(4) frequent intoxication or withdrawal symptoms when expected to fulfill major role obligations at work, school, or home (e.g., does not go to work because hung over, goes to school or work "high," intoxicated while taking care of his or her children), or when substance use is physically hazardous (e.g., drives when intoxicated)
(5) important social, occupational, or recreational activities given up or reduced because of substance use
(6) continued substance use despite knowledge of having a persistent or recurrent social, psychological, or physical problem that is caused or exacerbated by the use of the substance (e.g., keeps using heroin despite family arguments about it, cocaine-induced depression, or having an ulcer made worse by drinking)
(7) marked tolerance: need for markedly increased amounts of the substance (i.e., at least a 50% increase) in order to achieve intoxication or desired effect, or markedly diminished effect with continued use of the same amount

Note: The following items may not apply to cannabis, hallucinogens, or phencyclidine (PCP):

(8) characteristic withdrawal symptoms (see specific withdrawal syndromes under Psychoactive Substance-induced Organic Mental Disorders)
(9) substance often taken to relieve or avoid withdrawal symptoms

B. Some symptoms of the disturbance have persisted for at least one month, or have occurred repeatedly over a longer period of time.

Criteria for Severity of Psychoactive Substance Dependence:

Mild: Few, if any, symptoms in excess of those required to make the diagnosis, and the symptoms result in no more than mild impairment in occupational functioning or in usual social activities or relationships with others.

Moderate: Symptoms or functional impairment between "mild" and "severe."

Severe: Many symptoms in excess of those required to make the diagnosis, and the symptoms markedly interfere with occupational functioning or with usual social activities or relationships with others.[1]

In Partial Remission: During the past six months, some use of the substance and some symptoms of dependence.

In Full Remission: During the past six months, either no use of the substance, or use of the substance and no symptoms of dependence.

[1]Because of the availability of cigarettes and other nicotine-containing substances and the absence of a clinically significant nicotine intoxication syndrome, impairment in occupational or social functioning is not necessary for a rating of severe Nicotine Dependence.

PSYCHOACTIVE SUBSTANCE ABUSE

Psychoactive Substance Abuse is a residual category for noting maladaptive patterns of psychoactive substance use that have never met the criteria for dependence for that particular class of substance. The maladaptive pattern of use is indicated by either (1) continued use of the psychoactive substance despite knowledge of having a persistent or recurrent social, occupational, psychological, or physical problem that is caused or exacerbated by use of the substance or (2) recurrent use of the substance in situations when use is physically hazardous (e.g., driving while intoxicated). The diagnosis is made only if some symptoms of the disturbance have persisted for at least one month or have occurred repeatedly over a longer period of time.

This diagnosis is most likely to be applicable to people who have only recently started taking psychoactive substances and to involve substances, such as cannabis, cocaine, and hallucinogens, that are less likely to be associated with marked physiologic signs of withdrawal and the need to take the substance to relieve or avoid withdrawal symptoms.

Examples of situations in which this category would be appropriate are as follows:

1. A college student binges on cocaine every few weekends. These periods are followed by a day or two of missing school because of "crashing." There are no other symptoms.
2. A middle-aged man repeatedly drives his car when intoxicated with alcohol. There are no other symptoms.
3. A woman keeps drinking alcohol even though her physician has told her that it is responsible for exacerbating the symptoms of a duodenal ulcer. There are no other symptoms.

Diagnostic criteria for Psychoactive Substance Abuse

A. A maladaptive pattern of psychoactive substance use indicated by at least one of the following:
   (1) continued use despite knowledge of having a persistent or recurrent social, occupational, psychological, or physical problem that is caused or exacerbated by use of the psychoactive substance
   (2) recurrent use in situations in which use is physically hazardous (e.g., driving while intoxicated)

B. Some symptoms of the disturbance have persisted for at least one month, or have occurred repeatedly over a longer period of time.

C. Never met the criteria for Psychoactive Substance Dependence for this substance.

CLASSES OF PSYCHOACTIVE SUBSTANCES

Nine classes of psychoactive substances are associated with both abuse and dependence: alcohol; amphetamine or similarly acting sympathomimetics; cannabis; cocaine; hallucinogens; inhalants; opioids; phencyclidine (PCP) or similarly acting arylcyclohexylamines; and sedatives, hypnotics, or anxiolytics. Dependence (but not abuse) is seen with nicotine. (Although Nicotine Abuse is logically possible, according

to the definition of abuse noted above, in practice virtually no one who has not previously been dependent on nicotine uses nicotine-containing substances in a maladaptive way, e.g., episodic use of cigarettes that exacerbates a physical disorder.)

In this chapter, these ten classes of psychoactive substances appear in alphabetical order, although the following classes share similar features:

alcohol and sedatives, anxiolytics or hypnotics;

cocaine and amphetamine or similarly acting sympathomimetics;

hallucinogens and phencylidine (PCP) or similarly acting arylcyclohexylamines.

USE OF MULTIPLE SUBSTANCES

Psychoactive Substance Abuse and Dependence often involve several substances, either simultaneously or sequentially. For example, people with Cocaine Dependence frequently use alcohol, anxiolytics, or opioids to counteract lingering dysphoric anxiety symptoms. People with Opioid or Cannabis Abuse or Dependence usually have several other Psychoactive Substance Use Disorders, particularly of sedatives, hypnotics, or anxiolytics, amphetamines or similarly acting sympathomimetics, and cocaine.

When a person's condition meets the criteria for more than one Psychoactive Substance Use Disorder, multiple diagnoses should be made. The Polysubstance Dependence diagnosis is reserved for noting a period of at least six months during which the person was repeatedly using at least three categories of psychoactive substances (not including nicotine and caffeine), but no single psychoactive substance predominated. Further, during this period the dependence criteria were met for psychoactive substances (as a group), but not for any specific substance.

RECORDING SPECIFIC DIAGNOSES

The clinician should record the name of the specific psychoactive substance rather than the name of the class of substances, using the code number for the appropriate class. For example, the clinician should write 305.70 Amphetamine Abuse (rather than Amphetamine or Similarly Acting Sympathomimetic Abuse), 304.10 Diazepam Dependence (rather than Sedative, Hypnotic, or Anxiolytic Dependence), and 305.90 Cogentin Abuse (rather than Psychoactive Substance Abuse NOS).

OTHER FEATURES OF PSYCHOACTIVE SUBSTANCE USE DISORDERS

Route of administration. The route of administration of a psychoactive substance is an important variable in determining the likelihood that its use will lead to dependence or abuse. It may also affect the particular pattern of psychoactive substance use, i.e., determine whether periodic binges or daily use is more likely. In general, routes of administration that produce more rapid and efficient absorption of the substance into the bloodstream tend to increase the likelihood of an escalating pattern of substance use that leads to dependence. In addition, for some substances there is an increased likelihood of a binge pattern of use, i.e., a form of episodic use consisting of compressed time periods of continuous high dose use followed by one or more days of nonuse. For example, a person is much more likely to develop dependence on cocaine and develop a binge pattern of use when the substance is smoked or taken intravenously than when it is "sniffed" or taken orally.

Routes of administration that quickly deliver a large amount of the substance to the brain are also associated with higher levels of substance consumption, with a resulting increased likelihood of toxic effects. For example, the user of intravenous amphet-

amines is much more likely to consume large amounts of the substance and to develop a Psychoactive Substance-induced Organic Mental Disorder than the person who takes the substance only orally or intranasally.

Duration of psychoactive effects. The duration of psychoactive effects associated with a particular psychoactive substance is also an important variable in determining the likelihood that use of the substance will lead to dependence or abuse and a pattern of binge use. In general, relatively short-acting psychoactive substances, such as amphetamine, cocaine, and certain anxiolytics, tend to be more commonly used than substances with similar psychoactive effects, but longer action. Consequently, the shorter-acting psychoactive substances have a particularly high potential for the development of dependence or abuse.

Associated features. Repeated episodes of Psychoactive Substance-induced Intoxication are almost invariably present in Psychoactive Substance Abuse or Dependence, although for some substances it is possible to develop dependence without ever exhibiting frank intoxication (e.g., alcohol).

Personality disturbance and disturbance of mood are often present, and may be intensified by the Psychoactive Substance Use Disorder. For example, antisocial personality traits may be accentuated by the need to obtain money to purchase illegal substances. Anxiety or depression associated with Borderline Personality Disorder may be intensified as the person uses a psychoactive substance in an unsuccessful attempt to treat his or her mood disturbance.

In chronic abuse or dependence, mood lability and suspiciousness, both of which can contribute to violent behavior, are common.

Age at onset. Alcohol Abuse and Dependence usually appear in the 20s, 30s, and 40s. Dependence on amphetamine or similarly acting sympathomimetics, cannabis, cocaine, hallucinogens, nicotine, opioids, and phencyclidine (PCP) or similarly acting arylcyclohexylamines more commonly begin in the late teens and 20s. When a Psychoactive Substance Use Disorder begins in early adolescence, it is often associated with Conduct Disorder and failure to complete school.

Complications. The abuse or dependence associated with each class of psychoactive substances may cause an Organic Mental Syndrome. For example, prolonged Alcohol Dependence may cause Alcohol Withdrawal Delirium, Alcohol Amnestic Disorder, or Alcohol Hallucinosis. Similarly, Hallucinogen Delusional Disorder may be a complication of chronic hallucinogen use. Complications of the specific intoxication states, such as traffic accidents and physical injury due to Alcohol Intoxication, have been noted in the Organic Mental Disorders section.

Frequently there is a deterioration in the general level of physical health. Malnutrition and a variety of other physical disorders may result from failure to maintain physical health by proper diet and adequate personal hygiene.

Use of contaminated needles for intravenous administration of amphetamines, cocaine, and opioids can cause hepatitis, tetanus, vasculitis, septicemia, subacute bacterial endocarditis, embolic phenomena, malaria, and Human Immunodeficiency Virus (HIV)-related disorders (e.g., Acquired Immune Deficiency Syndrome [AIDS], AIDS-related Complex [ARC]). Materials used to "cut" the substances can cause toxic or allergic reactions. Using cocaine intranasally ("snorting") sometimes causes erosion of the nasal septum. Cocaine use can result in sudden death from cardiac arrhythmias, myocardial infarction, a cerebrovascular accident, or respiratory arrest.

Physical complications of chronic Alcohol Dependence include hepatitis, cirrhosis, peripheral neuropathy, gastritis, and a variety of reproductive disorders. In addition, chronic Alcohol Dependence increases the risk and severity of heart disease, pneumonia, tuberculosis, and neurologic disorders. The long-term potential for respiratory disorder with chronic cannabis use is controversial. The long-term physical complications from chronic and heavy nicotine use are discussed on page 182.

Depressive symptoms are a frequent complication of Psychoactive Substance Use Disorders and partly account for the high rate of suicide by people with these disorders. Suicide associated with alcohol and other psychoactive substances can occur in both intoxicated and sober states.

Long-term dependence on certain psychoactive substances, particularly cannabis, hallucinogens, and PCP, is often associated with a generalized reduction in goal-directed behaviors, e.g., going to school, work, and the pursuit of hobbies, even when the person does not take the substance for long periods of time. This is often accompanied by depression, anxiety, irritability, and mild deficits in cognitive functioning, e.g., difficulty concentrating. This has been called the "amotivational syndrome." It is unclear whether this syndrome is the direct consequence of the chronic effect of the psychoactive substances on the central nervous system or whether it is an expression of preexisting psychopathology.

Impairment. Impairment in social and occupational functioning is frequently marked, particularly with dependence.

Course. Brief, self-limited episodes of dependence or abuse may occur, particularly during periods of psychosocial stress. More commonly, the course is chronic, lasting several years, with periods of exacerbation and partial or full remission.

Predisposing factors. Conduct Disorder in children, and Personality Disorders, particularly Antisocial Personality Disorder, predispose to the development of Psychoactive Substance Use Disorders. Children of people who themselves have Psychoactive Substance Use Disorders are at higher risk for developing these disorders.

Sex ratio. Psychoactive Substance Use Disorders are diagnosed more commonly in males than in females.

Differential Diagnosis. For a discussion of the role of toxicologic analysis of body fluids in the differential diagnosis of Psychoactive Substance Use Disorders, see p. 125.

Nonpathologic psychoactive substance use for recreational or medical purposes is not associated with the dependence syndrome, or a maladaptive pattern of use (abuse).

Repeated episodes of Psychoactive Substance-induced Intoxication are almost invariably present in Psychoactive Substance Abuse and Dependence, although for some substances (e.g., alcohol) it is possible to develop dependence without ever exhibiting frank intoxication (e.g., alcohol). However, one or more episodes of Psychoactive Substance-induced Intoxication alone are not sufficient for a diagnosis of either Psychoactive Substance Dependence or Abuse.

DESCRIPTIONS OF PSYCHOACTIVE SUBSTANCE USE DISORDERS

Diagnostic criteria for dependence categories will be found on p. 167. Diagnostic criteria for abuse categories are on p. 169.

303.90 Alcohol Dependence
305.00 Alcohol Abuse

See Alcohol-induced Organic Mental Disorders (p. 127) for a description of Alcohol Intoxication, Alcohol Idiosyncratic Intoxication, Uncomplicated Alcohol Withdrawal, Alcohol Withdrawal Delirium, Alcohol Hallucinosis, Alcohol Amnestic Disorder, and Dementia Associated with Alcoholism.

Most adults in the United States are light drinkers. About 35% abstain, 55% drink fewer than three alcoholic drinks a week, and only 11% consume an average of one ounce or more of alcohol a day.

Drinking patterns vary by age and sex. For both males and females, the prevalence of drinking is highest and abstention is lowest in the 21-34-year age range. At all ages, two to five times more males than females are "heavy" drinkers, although, because of differences in weight and body water, different standards should be used to define "heavy" drinking in females. For ages 65 years and older, abstainers exceed drinkers in both sexes, and only 7% of males and 2% of females are considered heavy drinkers.

Most alcohol is consumed by a small percentage of people: 10% of drinkers consume 50% of the total amount of alcohol consumed.

Patterns of use. There are three main patterns of chronic Alcohol Abuse or Dependence. The first consists of regular daily intake of large amounts; the second, of regular heavy drinking limited to weekends; the third, of long periods of sobriety interspersed with binges of daily heavy drinking lasting for weeks or months. It is a mistake to associate one of these particular patterns exclusively with "alcoholism."

Some investigators divide alcoholism into "species" depending on the pattern of drinking. One species, so-called gamma alcoholism, is common in the United States and conforms to the stereotype of the alcoholism seen in people who are active in Alcoholics Anonymous. Gamma alcoholism involves problems with "control": once the person with gamma alcoholism begins to drink, he or she is unable to stop until poor health or depleted financial resources prevent further drinking. Once the "bender" is terminated, however, the person is able to abstain from alcohol for varying lengths of time.

Gamma alcoholism is often compared with a "species" of alcoholism common in France. In this, the person with alcoholism is not aware of lack of control: he or she *must* drink a given quantity of alcohol every day, but there is no compulsion to exceed that amount. The person may not recognize that he or she has an alcohol problem until, for some reason, he or she has to stop drinking and develops withdrawal symptoms.

Although these two pure types of alcoholism do exist, they do not conform to the pattern of drinking seen in most people with Alcohol Abuse or Dependence in the United States.

Associated features. Alcohol Dependence and Abuse are often associated with use and abuse of other psychoactive drugs, including cannabis, cocaine, heroin, amphetamines, and various sedatives and hypnotics. Frequent and often simultaneous use of alcohol plus several of the above substances is most commonly seen in adolescents and people under 30. Use and abuse of benzodiazepines combined with alcohol are more common in middle life. Although benzodiazepines are contraindicated in the treatment of alcoholism, these agents are often prescribed by a physician in a misguided attempt to stop or reduce a patient's drinking.

Whether most people with Alcohol Dependence are at particular risk to develop dependence or abuse of other drugs is not definitely known, but certainly some are. Nicotine Dependence is especially common.

Alcohol Dependence is often associated with depression, but usually the depression appears to be a consequence, not a cause, of the drinking. In Bipolar Disorder, alcohol intake increases more often during Manic Episodes than during depressions. Anxiety Disorders—particularly agoraphobia in females and Social Phobia in males—occur in a sizable minority of people with Alcohol Abuse or Dependence, their onset often preceding the heavy drinking.

Course. The natural history of alcoholism seems to be somewhat different in males and females. In males the onset is usually in the late teens or the 20s, the course is insidious, and the person may not be fully aware of his dependence on alcohol until the 30s. The first hospitalization usually occurs in the late 30s or 40s. In males, symptoms of Alcohol Dependence or Abuse rarely occur for the first time after age 45. If they do occur, a Mood Disorder or Organic Mental Disorder should be considered as a source of symptoms.

Alcohol Dependence has a higher "spontaneous" remission rate than is often recognized. The frequency of admissions to psychiatric hospitals for alcoholism drops markedly in the sixth and seventh decades of life, as do first arrests for alcohol-related offenses. Although the mortality rate among people with Alcohol Dependence is perhaps two to three times that of the general population, this is probably insufficient to account for the apparent decrease in problem drinking in middle and late middle life.

Females with Alcohol Dependence have been studied less extensively than males, but the evidence suggests that the course of the disorder is more variable in females. The onset often occurs later, and spontaneous remission apparently is less frequent. Females with alcoholism are also more likely to have a history of a Mood Disorder.

Drinking problems may occur in various sequences. Frequently, after years of heavy problem-free drinking, a person may experience many problems in a brief period.

As people drink more over days, months, and years, they gradually *need* to drink more to obtain the same effect. This is called tolerance. A person with severe chronic Alcohol Dependence may be able to drink, at most, twice as much as a teetotaler of similar age and health. Compared with tolerance for morphine, which can be considerable, tolerance for alcohol is modest.

More striking than "acquired" tolerance may be inborn tolerance. People vary widely in the amount of alcohol they can tolerate, independently of their drinking experience. Some people, however hard they try, cannot drink more than a small amount of alcohol without developing a headache, upset stomach, or dizziness. Others seem able to drink large amounts with hardly any bad effects; they appear to have been born with this capacity, not to have developed it entirely from practice.

Differences in tolerance for alcohol apply not only to people but to racial groups. For example, many Orientals develop flushing of the skin, sometimes with nausea, after drinking only a small amount of alcohol.

Prevalence. A community study in the United States, conducted from 1981 to 1983 and using DSM-III criteria, indicated that approximately 13% of the adult population had had Alcohol Abuse or Dependence at some time in their lives.

Familial Pattern. Alcohol Dependence tends to cluster in families. Recent evidence, based on adoption studies, indicates that the transmission of Alcohol Dependence from generation to generation does not require environmental exposure to

family members with alcohol problems: it occurs at increased rates even when the children are reared by adoptive parents without alcohol problems, which suggests a genetic influence in the disorder.

304.40 Amphetamine or Similarly Acting Sympathomimetic Dependence
305.70 Amphetamine or Similarly Acting Sympathomimetic Abuse

See Amphetamine- or Similarly Acting Sympathomimetic-induced Organic Mental Disorders (p. 134) for a description of Amphetamine or Similarly Acting Sympathomimetic Intoxication, Withdrawal, Delirium, and Delusional Disorder.

This group includes all of the substances of the substituted phenylethylamine structure, such as amphetamine, dextroamphetamine, and methamphetamine ("Speed"), and those with structures different from the substituted phenylethylamine that have amphetaminelike action, such as methylphenidate and some substances used as appetite suppressants ("diet pills"). These substances are typically taken orally or intravenously, though methamphetamine is frequently taken by nasal inhalation (like cocaine).

The patterns of use, associated features, and course of Amphetamine Dependence and Abuse are very similar to those of Cocaine Dependence and Abuse since both substances are potent central nervous system stimulants with similar psychoactive and sympathomimetic effects. Controlled studies have shown that experienced users are unable to distinguish amphetamine from cocaine. One of the few differences between the two classes of substances is that the psychoactive effects of amphetamine last longer and its peripheral sympathomimetic effects may be more potent.

Patterns of use. Many people who develop Amphetamine Dependence or Abuse first start using amphetamine or related substances for their appetite-suppressant effect in an attempt at weight control.

Amphetamine Dependence and Abuse are usually characterized by either episodic or chronic daily, or almost daily, use. In episodic use, the amphetamine use tends to be separated by several days of nonuse, e.g., the substance may be used on weekends and once or twice during the week. "Bingeing" is a common form of episodic use consisting of compressed time periods of continuous high-dose use followed by one or more days of nonuse, e.g., consumption of several grams or more of amphetamine during a single 48-hour period, followed by a one- or two-day recuperation period, and then another binge. Binges tend to terminate only when the user collapses from physical exhaustion or when amphetamine supplies are depleted. Binges are generally followed by an extremely intense and unpleasant "crash" (see p. 135) requiring at least two or more days of recuperation. In some cases the "crash" may extend into Amphetamine Withdrawal (see p. 136) lasting several days.

Chronic daily, or almost daily, use may be at high or low doses. Use may be throughout the course of a day or be restricted to certain hours, e.g., only during working hours or only during the evening. In this pattern there are usually no wide fluctuations in the amount of amphetamine used on successive occasions, but there is often a general increase in doses over time.

Associated features. Often the user of amphetamine also abuses or is dependent on alcohol or a sedative, hypnotic, or anxiolytic, which is taken in an attempt to alleviate the unpleasant aftereffects of Amphetamine Intoxication.

Psychological and behavioral changes associated with Amphetamine Abuse and Dependence include depression, irritability, anhedonia, anergia, and social isolation.

Sexual dysfunction, paranoid ideation, attentional disturbances, and memory problems may also occur.

Course. Intravenous administration of amphetamine tends to engender a rapid progression from infrequent amphetamine use to Amphetamine Abuse or Dependence, often within only a few weeks or months. Intranasal administration of amphetamine flakes tends to engender a more gradual progression to Amphetamine Abuse or Dependence, which may not be clearly evident for months or years after initial use.

Amphetamine Abuse and Dependence are usually associated with a progressive tolerance to the desired effects of the substance, which leads to use of increasing doses. Continuing use produces a progressive diminution in pleasurable effects and a corresponding increase in dysphoric effects. Eventually, a point is reached at which the person still craves the amphetamine, despite the absence of substance-induced euphoria because of tolerance, and an accumulation of unpleasant adverse effects from the continued drug-taking. Continuing use of amphetamine appears to be driven by persistent craving for the substance rather than attempts to avoid or alleviate withdrawal symptoms (as is typically seen in Opioid Dependence).

Prevalence. A community study in the United States, conducted from 1981 to 1983 and using DSM-III criteria, indicated that approximately 2% of the adult population had had Amphetamine or Similarly Acting Sympathomimetic Abuse at some time in their lives.

304.30 Cannabis Dependence
305.20 Cannabis Abuse

See Cannabis-induced Organic Mental Disorders (p. 139) for a description of Cannabis Intoxication and Delusional Disorder.

This group includes all substances with psychoactive properties derived from the cannabis plant plus chemically similar synthetic substances. In the United States the most commonly used substances are marijuana, hashish, and, occasionally, purified delta-9-tetrahydrocannabinol (THC), the major psychoactive ingredient in these substances. These psychoactive substances are almost always smoked, but may also be taken orally, sometimes mixed with food.

The THC content of the marijuana that is generally available varies greatly. The THC content of illicit marijuana has increased significantly since the late 1960s, from an average of approximately 1%–5% to as much as 10%–15% by the mid 1980s. The greater potency of current marijuana supplies may be contributing to an increasing prevalence of Cannabis Dependence and associated disorders.

Patterns of use. Cannabis is regarded by many people as a substance of low abuse potential that is extremely unlikely to cause any problems with continued use. For that reason, many people start using the substance without any appreciation of its capacity to induce dependence.

Cannabis Dependence is usually characterized by daily, or almost daily, use of the substance. In Cannabis Abuse, the person uses the substance episodically, but shows evidence of maladaptive behavior, such as driving while impaired by Cannabis Intoxication.

Since impairment in social and occupational functioning and the development of related physical disorders in Cannabis Dependence are less than those typically seen with other psychoactive substances, such as alcohol, cocaine, and heroin, people with Cannabis Dependence and Abuse rarely seek treatment for these disorders.

Associated features. Cannabis is used in combination with other substances, particularly alcohol and cocaine. Psychological symptoms associated with Cannabis Dependence include lethargy, anhedonia, and attentional and memory problems.

Course. Cannabis Dependence or Abuse usually develops with repeated use over a substantial period of time; rapid development following initial use is rare. Tolerance may develop to some of the substance's psychoactive effects and thus promote increased levels of consumption. However, this is usually not marked, and rarely is there an abrupt escalation of the amount of the substance consumed with each use. Typically, it is the frequency rather than the absolute amount of cannabis used that increases over time. With chronic heavy use there is often a diminution or loss of the pleasurable effects of the substance. There may be a corresponding increase in dysphoric effects, but this is not seen as frequently as in chronic heavy use of amphetamine or cocaine.

Prevalence. Cannabis is the most widely used illicit psychoactive substance in the United States. A community study in the United States, conducted from 1981 to 1983 and using DSM-III criteria, indicated that approximately 4% of the adult population had had Cannabis Abuse at some time in their lives.

304.20 Cocaine Dependence
305.60 Cocaine Abuse

See Cocaine-induced Organic Mental Disorders (p. 141) for a description of Cocaine Intoxication, Withdrawal, Delirium, and Delusional Disorder.

Several different types of coca preparations are used for their psychoactive properties: coca leaves (chewed), coca paste (smoked), cocaine hydrochloride powder (inhaled or injected), and cocaine alkaloid—"freebase" or "crack" (smoked).

The chewing of coca leaves is a practice generally limited to native populations in Central and South American cocaine-producing countries. In order to achieve the mild stimulant effects from chewing the leaves, the cocaine alkaloid from the leaf is released by simultaneously chewing a piece of another plant that contains an alkaline substance. This practice has rarely been known to cause an Organic Mental Syndrome or Abuse or Dependence.

Coca paste is a crude extract of the coca leaf prepared by adding organic solvents, such as kerosene or gasoline combined with sulfuric acid. Coca paste is usually smoked in a pipe, or is sometimes mixed in a cigarette with tobacco or cannabis. The availability of coca paste has been limited almost exclusively to cocaine-producing countries in Central and South America, in some of which this highly toxic and addictive form of cocaine, contaminated by the solvents used in the extraction process, has been causing increasing mental and physical disorders among the native populations.

As with all smokable forms of cocaine, the intensity of psychoactive effects and the addiction potential of the substance are maximized by its extremely rapid and efficient absorption by the lungs and subsequent circulation to the brain within only a few seconds after inhalation of the smoke.

The most commonly used form of cocaine in the United States is cocaine hydrochloride powder, which is usually inhaled through the nostrils, and then absorbed into the bloodstream through the mucous membranes. Cocaine hydrochloride is soluble in water, and thus can also be administered by intravenous injection; it is sometimes

mixed with heroin in the same syringe, yielding a drug combination known as a "speedball." This mixture is particularly dangerous since the cocaine and heroin act synergistically in depressing respiratory function. Cocaine powder is not smoked because the substance decomposes at the temperatures required for smoking.

The prevalence of smoking cocaine in its alkaloid form began to increase rapidly in the United States in about 1984. The cocaine alkaloid is extracted or "freed" from the powdered hydrochloride salt through use of one of several different reagents, such as ether, ammonia, or sodium bicarbonate (baking soda). When the user performs the extraction from cocaine powder, the resulting cocaine alkaloid is commonly called "freebase." Cocaine in this form has a much lower volatility point, and therefore is not destroyed by the heat necessary to change it into a gas, as is the case with cocaine hydrochloride. When cocaine is purchased in its alkaloid form, it is commonly called "crack" or "rock," although pharmacologically it is the same as "freebase" cocaine. The appeal of smokable cocaine is due to a combination of factors, including its familiar and seemingly benign method of administration and its extremely rapid and potent psychoactive effects.

Patterns of use. Cocaine Abuse and Dependence are associated with two different patterns of use: episodic, and chronic daily, or almost daily, use. In episodic use, the cocaine use tends to be separated by two or more days of nonuse, e.g., it may be used on weekends and once or twice during the week. "Bingeing" is a common form of episodic use consisting of compressed time periods of continuous high-dose use, e.g., consumption of several grams or more of cocaine during a single 48-hour period. Bingeing is most commonly associated with cocaine smoking and intravenous use. Binges tend to terminate only when the user collapses from physical exhaustion or when cocaine supplies are depleted. Binges are generally followed by an extremely intense and unpleasant "crash" (see p. 135) requiring at least two or more days of recuperation. In some cases the "crash" may extend into Cocaine Withdrawal (see p. 142) lasting several days.

Chronic daily, or almost daily, use may be at high or low doses. Use may be throughout the course of a day or be restricted to certain hours, e.g., only during working hours or only during the evening. In this pattern there are usually no wide fluctuations in the amount of cocaine used on successive days, but there is often a general increase in doses used over time.

Associated features. Often the user of cocaine also abuses or is dependent on alcohol or a sedative, hypnotic, or anxiolytic, which is taken in an attempt to alleviate the unpleasant aftereffects of Cocaine Intoxication.

Psychological and behavioral changes associated with Cocaine Abuse and Dependence include depression, irritability, anhedonia, anergia, and social isolation. Sexual dysfunction, paranoid ideation, attentional disturbances, and memory problems may also occur.

Course. Cocaine smoking and intravenous administration of cocaine tend to engender rapid progression from infrequent cocaine use to Cocaine Abuse or Dependence, often within only a few weeks or months. Intranasal administration of cocaine tends to result in more gradual progression to Cocaine Abuse or Dependence, which may not be clearly evident for months or years following initial use.

Cocaine Abuse and Dependence are usually associated with a progressive tolerance of the desirable effects of the substance, which leads to use of increasing doses. With continuing use there is a progressive diminution in pleasurable effects and a

corresponding increase in dysphoric effects. Eventually, a point is reached at which the person still craves the cocaine despite the absence of substance-induced euphoria because of tolerance, and an accumulation of unpleasant adverse effects caused by the continued drug-taking. Continuing use of cocaine appears to be driven by persistent craving and urges for the substance rather than attempts to avoid or alleviate withdrawal symptoms (as is typically seen in Opioid Dependence).

Prevalence. A community study in the United States, conducted from 1981 to 1983 and using DSM-III criteria (which did not contain a category for Cocaine Dependence), indicated that approximately 0.2% of the adult population had had Cocaine Abuse at some time in their lives. Because of the broadened criteria for Dependence included in this manual, and because of the definite increase in use in recent years, the prevalence of Cocaine Dependence is believed to be far higher than this now.

304.50 Hallucinogen Dependence
305.30 Hallucinogen Abuse

See Hallucinogen-induced Organic Mental Disorders (p. 144) for a description of Hallucinogen Hallucinosis, Hallucinogen Delusional Disorder, Hallucinogen Mood Disorder, and Post-hallucinogen Perception Disorder.

This group includes two types of psychoactive substances, both of which have hallucinogenic properties: substances structurally related to 5-hydroxytryptamine (e.g., lysergic acid diethylamine [LSD] and dimethyltryptamine [DMT]), and substances related to catecholamine (e.g., mescaline). Phencyclidine (PCP), although it is sometimes referred to as an hallucinogen, is classified separately since it rarely causes a pure hallucinosis.

Hallucinogens are taken orally.

Pattern of use. Most people are introduced to a hallucinogen by "experimenting" with the substance. Some find the hallucinosis extremely dysphoric and stop using the substance, whereas others enjoy the experience and continue its use. Use is almost always episodic, because the psychoactive effects of these substances impair normal cognitive and perceptual functions so markedly that the user generally must set aside time from normal daily activities to take the substance. In addition, frequent use may lead to rapid development of marked tolerance, which makes it virtually impossible to take enough of the substance on a daily basis to obtain the desired effects. For these reasons, abuse is much more common than dependence.

Associated features. Hallucinogens are frequently contaminated with other drugs, such as PCP and amphetamine. In addition, users frequently smoke cannabis and abuse alcohol.

Course. The course is unpredictable, and is probably related to the nature of the underlying pathology that played a role in onset of its use. Most people rapidly resume their former life-style after only a brief period of abuse or dependence.

Prevalence. Among people seeking help for dependence on psychoactive substances, the use of hallucinogens as the predominant substance is extremely rare. A community study in the United States, conducted from 1981 to 1983 and using DSM-III criteria, indicated that approximately 0.3% of the adult population had had Hallucinogen Abuse at some time in their lives.

304.60 Inhalant Dependence
305.90 Inhalant Abuse

See Inhalant-induced Organic Mental Disorders (p. 148) for a description of Inhalant Intoxication.

Included in this classification are disorders induced by inhaling, through the mouth or nose, the aliphatic and aromatic hydrocarbons found in substances such as gasoline, glue, paint, paint thinners, and spray paints. Less commonly used are the halogenated hydrocarbons found in cleaners, typewriter correction fluid, and spray-can propellants and other volatile compounds containing esters, ketones, and glycols. These volatile substances are available in a wide variety of commercial products, and may be used interchangeably, depending on availability and personal preference. There may be subtle differences in the psychoactive and physical effects of the different compounds, but not enough is known about their differential effects to distinguish among them. All are capable of producing Intoxication.

Most compounds that are inhaled are a mixture of several substances that can produce psychoactive effects. Therefore, under most circumstances, it is difficult to ascertain the exact substance responsible for the disorder. Unless there is clear evidence that a single, unmixed substance has been used, the general term "inhalant" should be used in recording the diagnosis.

Specifically excluded from these diagnoses are dependence patterns resulting from the use of anesthetic gases (e.g., nitrous oxide, ether) and short-acting vasodilators such as amyl or butyl nitrite. These should be listed under 304.90 Psychoactive Substance Dependence NOS.

Patterns of use. Several methods are used to inhale intoxicating vapors. Most commonly, a rag soaked with the substance is applied to the mouth and nose and the vapors are breathed in. The substance may also be placed in a paper or plastic bag, and the gases in the bag inhaled. Substances may also be inhaled directly from containers, or from aerosols sprayed in the mouth or nose. There are rare reports of using heating compounds to accelerate vaporization. The inhalants reach the lungs, bloodstream, and target sites very rapidly. Use of different methods combined with varying concentrations of inhalants in the products used cause highly variable concentrations in the body, making it extremely difficult to match dose to effect.

The background of inhalant users is generally marked by considerable family dysfunction (separation, poor supervision, Alcohol or other Psychoactive Substance Dependence), and school or work adjustment problems (delinquency, truancy, poor grades, dropping out of school, unemployment). There is a higher incidence of inhalant use among minority youth living in economically depressed areas, although dependence has been documented among all racial, gender, and socioeconomic groups.

The pattern of development of Inhalant Dependence is related to age. Inhalants are sometimes used by quite young children, 9–13 years old, generally with a group of peers who are likely to use alcohol and cannabis as well. Inhalant use may increase gradually over time until inhalants become the preferred substance, and the peer group meets frequently to use inhalants together. Older adolescents and young adults who have Inhalant Dependence are likely to have used many different substances as adolescents and to have gradually increased inhalant use until inhalants have become the preferred substance.

Cases have also been reported of the development of dependence in industrial workers who have long-term exposure and access to volatile compounds. In these instances a worker may begin to use the compound intentionally for its psychoactive effects and subsequently develop a pattern diagnosable as dependence.

Associated features. Users of inhalants nearly always use other psychoactive substances as well. When Inhalant Dependence exists, however, it is usually clear that inhalants are the preferred substance, and inhalants are used regularly whereas other substances are used only sporadically. Even occasional users of inhalants are likely to have significant physical and mental problems.

Course. Younger children diagnosed as having Inhalant Dependence may use inhalants several times a week, often on weekends and after school. Severe dependence in young adults may involve varying periods of intoxication throughout each day and occasional periods of heavier use that may last several days. This pattern may persist for many years, with recurrent need for treatment. Users of inhalants may have a preferred level or degree of intoxication, and the method of administration allows a user to maintain that specific level for several hours. Chronic heavy users of inhalants may develop renal and hepatic complications.

Tolerance to inhalants has been reported, but may be merely increased use over time, with more periods of intoxication and increased preference for higher levels of intoxication. Withdrawal has also been reported, but there is inadequate evidence to substantiate its existence.

Prevalence. No information.

305.10 Nicotine Dependence

See Nicotine-Induced Organic Mental Disorders (p. 150) for a description of Nicotine Withdrawal.

Patterns of use. At present, the most common form of Nicotine Dependence is associated with the inhalation of cigarette smoke. Pipe- and cigar-smoking, the use of snuff, and the chewing of tobacco are less likely to lead to Nicotine Dependence. The more rapid onset of nicotine effects with cigarette-smoking leads to a more intensive habit pattern that is more difficult to give up because of the frequency of reinforcement and the greater physical dependence on nicotine.

Associated features. People with this disorder are often distressed because of their inability to stop nicotine use, particularly when they have serious physical symptoms that are aggravated by nicotine. Some people who have Nicotine Dependence may have difficulty remaining in social or occupational situations in which smoking is prohibited.

Course. The course of Nicotine Dependence is variable. Most people repeatedly attempt to give up nicotine use without success. In some the dependence is brief, in that when they experience concern about nicotine use, they promptly make an effort to stop smoking and are successful, though in many cases they may experience a period of Nicotine Withdrawal lasting from days to weeks. Studies of treatment outcome suggest that the relapse rate is greater than 50% in the first 6 months, and at least 70% within the first 12 months. After a year's abstinence, subsequent relapse is unlikely.

The difficulty in giving up nicotine use definitively, particularly cigarettes, may be due to the unpleasant nature of the withdrawal syndrome, the deeply engrained nature of the habit, the repeated effects of nicotine, which rapidly follow the inhalation of cigarette smoke (75,000 puffs per year for a pack-a-day smoker), and the likelihood that a desire to use nicotine is elicited by environmental cues, such as the ubiquitous

presence of other smokers and the widespread availability of cigarettes. When efforts to give up smoking are made, Nicotine Withdrawal may develop.

Impairment. Since nicotine, unlike alcohol, rarely causes any clinically significant state of intoxication, there is no impairment in social or occupational functioning as an immediate and direct consequence of its use.

Complications. The most common complications are bronchitis, emphysema, coronary artery disease, peripheral vascular disease, and a variety of cancers.

Prevalence and sex ratio. A large proportion of the adult population of the United States has Nicotine Dependence, the prevalence among males being greater than that among females. Among teen-age smokers, males are affected approximately as often as females.

Familial pattern. Cigarette smoking among first-degree biologic relatives of people with Nicotine Dependence is more common than among the general population. Evidence for a genetic factor has been documented, but the effect is modest.

304.00 Opioid Dependence
305.50 Opioid Abuse

See Opioid-induced Organic Mental Disorders (p. 151) for a description of Opioid Intoxication and Withdrawal.

This group includes natural opioids, such as heroin and morphine, and synthetics with morphinelike action, which act on opiate receptors. These compounds are prescribed as analgesics, anesthetics, or cough-suppressants. They include codeine, hydromorphone, meperidine, methadone, oxycodone, and others. Several other compounds that have both direct opiatelike agonist effects and antagonist effects are included in this class of substances because they often produce the same physiologic and behavioral effects as pure opioids, e.g., pentazocine and buprenorphine. Prescription opiates are typically taken orally in pill form, but can also be taken intravenously; heroin is typically taken intravenously, but can also be taken by nasal inhalation or smoking. Regular use of these substances leads to remarkably high levels of tolerance.

Although methadone is included in this class, people properly supervised in a methadone maintenance program should not develop any of the Opioid-induced Organic Mental Disorders. When the criteria for one of these diagnoses are met, this indicates that there has been nonmedical use of methadone, in which case the appropriate diagnosis should be made.

Patterns of use. There are two patterns of development of dependence and abuse. In one, which is relatively infrequent, the person originally obtained an opioid by prescription, from a physician, for the treatment of pain or cough-suppression, but has gradually increased the dose and frequency of use on his or her own. The person continues to justify the substance use on the basis of treatment of symptoms, but substance-seeking behavior becomes prominent, and the person may go to several physicians in order to obtain sufficient supplies of the substance.

A second pattern that leads to dependence or abuse involves young people in their teens or early 20s who, with a group of peers, use opioids obtained from illegal sources. Some use an opioid alone to obtain a "high," or euphoria. Others use these substances in combination with amphetamines, cannabis, hallucinogens, or sedatives to enhance the euphoria or to counteract the depressant effect of the opioid. In this

pattern, the first use of opioids may have been preceded by a period of "polysubstance use," which may have involved alcohol, amphetamines, cannabis, hallucinogens, nicotine, sedatives, hypnotics, anxiolytics, or prescription and nonprescription cough syrups. The use of these other psychoactive substances generally continues after the use of opioids is established.

Course. Once a pattern of Opioid Abuse or Dependence is established, substance procurement and use generally dominate the person's life.

In Opioid Dependence, the course is a function of the context of the addiction. For example, the vast majority of people who became dependent on heroin in Vietnam did not return to their addiction when back in the United States. In contrast, it is believed that most people who become dependent on opioids in the United States become involved in a chronic behavioral pattern, marked by remissions while in treatment or prison or when the substance is scarce and relapses on returning to a familiar environment in which these substances are available and friends or colleagues also use them.

In the United States, in this century, people with Opioid Dependence have had a high annual death rate (approximately 10 per 1,000) because of the physical complications of the disorder and a life-style often associated with violence. Among those who survive, increasing abstinence is observed with the passage of years, dependence coming to an end, on average, within about nine years after its onset. However, for many people with Opioid Dependence, the dependence continues throughout life.

Prevalence. A community study in the United States, conducted from 1981 to 1983 and using DSM-III criteria, indicated that approximately 0.7% of the adult population had had Opioid Abuse or Dependence at some time in their lives.

304.50 Phencyclidine (PCP) or Similarly Acting Arylcyclohexylamine Dependence

305.90 Phencyclidine (PCP) or Similarly Acting Arylcyclohexylamine Abuse

See Phencyclidine (PCP)- or Similarly Acting Arylcyclohexylamine-induced Organic Mental Disorders (p. 154) for a description of Phencyclidine (PCP) or Similarly Acting Arylcyclohexylamine Intoxication, Delirium, Delusional Disorder, Mood Disorder, and Organic Mental Disorder NOS.

This group of psychoactive substances includes phencyclidine (PCP) and similarly acting compounds such as ketamine (Ketalar) and the thiophene analogue of phencyclidine (TCP). These substances can be taken orally or intravenously, or can be smoked or inhaled. Within this class of substances, phencyclidine is the most commonly used. It is sold on the street under a variety of names, the most common of which are PCP, PeaCe Pill, and angel dust.

Patterns of use. Most people are introduced to PCP when it is present as a contaminant of other illegal psychoactive substances, such as amphetamine and related substances, cannabis, cocaine, or hallucinogens. The person suspects that PCP is the active ingredient and then seeks PCP specifically. PCP is usually taken episodically in binges and "runs" that can last several days. However, there are some people who chronically use the substance on a daily basis.

Whether or not tolerance and withdrawal symptoms develop with use of these substances is currently unclear.

Associated features. Many heavy users of PCP are also heavy users of alcohol and cannabis.

Course. Usually abuse or dependence develops after only a short period of occasional use of the psychoactive substance. The "experimental" user either finds the substance too unpredictable in its effects and abandons further use, or quickly becomes a heavy user and develops abuse or dependence. The motivation for continued use of the substance is apparently its euphoric effect, not avoidance or relief of withdrawal symptoms.

Prevalence. The use of PCP as the predominant substance among people seeking help for dependence on psychoactive substances is relatively rare.

304.10 Sedative, Hypnotic, or Anxiolytic Dependence
305.40 Sedative, Hypnotic, or Anxiolytic Abuse

See Sedative-, Hypnotic-, or Anxiolytic-induced Organic Mental Disorders (p. 158) for a description of Sedative, Hypnotic, or Anxiolytic Intoxication, Withdrawal, Withdrawal Delirium, and Amnestic Disorder.

Hypnotics, or "sleeping pills," include benzodiazepines such as flurazepam, triazolam, and temazepam, and other substances unrelated to benzodiazepines, such as ethchlorvynol, glutethimide, chloral hydrate, methaqualone, and the barbiturates. Benzodiazepines are also used for the treatment of anxiety and are the most commonly prescribed psychoactive medications.

Although these psychoactive substances differ widely in their mechanisms of action, rates of absorption, metabolism, and distribution in the body, at some dose and at some duration of use, they are all capable of producing similar syndromes of intoxication and withdrawal. Substances in this category are usually taken orally.

Patterns of use. There are two patterns of development of dependence and abuse. In one, the person originally obtained the psychoactive substance by prescription from a physician for treatment of anxiety or insomnia, but has gradually increased the dose and frequency of use on his or her own. The person continues to justify the use on the basis of treating symptoms, but substance-seeking behavior becomes prominent, and the person may go to several doctors in order to obtain sufficient supplies of the substance. Tolerance can be remarkable, with doses of more than 100 mg of diazepam daily producing little sedation.

It should be noted that there are people who continue to take benzodiazepine medication according to a physician's direction for a legitimate medical indication such as symptoms of chronic severe anxiety. These people would not ordinarily develop symptoms that meet the criteria for dependence because they are not preoccupied with obtaining the substance, and its use does not interfere with their performing their normal social or occupational roles. On the contrary, the benzodiazepine may make normal functioning possible. Nevertheless, these people are likely to develop "physical dependence" on benzodiazepines in the pharmacologic sense because a withdrawal syndrome would ensue if the use of the substance were terminated abruptly.

A second pattern, more frequent than the first, that leads to dependence involves young people in their teens or early 20s who, with a group of peers, use substances obtained from illegal sources. The initial objective is to obtain a "high," or euphoria, when the substance is used alone. Others use these substances in combination with opioids to enhance the euphoria or to counteract the stimulant effects of cocaine or amphetamine. An initial pattern of intermittent use at parties can lead to daily use and

remarkable levels of tolerance. Ingestion of doses of 500 to 1,500 mg of diazepam or its equivalent have been observed, and there is evidence of strong substance-seeking behavior and resort to illegal sources of supply.

Course. The most common course is heavy daily use that results in dependence. A significant number of people with dependence eventually stop using the substance and recover completely, even from the physical complications of the disorder.

Prevalence. A community study in the United States, conducted from 1981 to 1983 and using DSM-III criteria, indicated that approximately 1.1% of the adult population had had Sedative, Hypnotic, or Anxiolytic Abuse or Dependence at some time in their lives.

304.90 Polysubstance Dependence

This category should be used when, for a period of at least six months, the person has repeatedly used at least three categories of psychoactive substances (not including nicotine and caffeine), but no single psychoactive substance has predominated. During this period the criteria have been met for dependence on psychoactive substances as a group, but not for any specific substance.

304.90 Psychoactive Substance Dependence Not Otherwise Specified

This is a residual category for disorders in which there is dependence on a psychoactive substance that cannot be classified according to any of the previous categories (e.g., anticholinergics), or for use as an initial diagnosis in cases of dependence in which the specific substance is not yet known.

305.90 Psychoactive Substance Abuse Not Otherwise Specified

This is a residual category for disorders in which there is abuse of a psychoactive substance that cannot be classified according to any of the previous categories (e.g., anticholinergics), or for use as an initial diagnosis in cases of abuse in which the specific substance is not yet known.

Appendix D—Sample Instruments

1. CATOR Adolescent Intake, History, and Discharge Forms
2. Adolescent Problem Severity Index (APSI)
3. Comprehensive Addiction Severity Index for Adolescents (CASI-A)
4. Prototype Screening/Triage Form for Juvenile Detention Centers

CATOR

ADOLESCENT INTAKE

Intake Date ___ ___ / ___ ___ / ___ ___

ID # ___ ___ ___ / ___ ___ ___ ___

Birth Date ___ ___ / ___ ___ / ___ ___

Sex ___ (1) Male ___ (2) Female

Facility _____

Facility Code ___ ___ ___ ___

1. ETHNIC ORIGIN
___ (1) White
___ (2) Hispanic
___ (3) Black
___ (4) Native American
___ (5) Other

RESIDENCE

County _____

State _____

REFERRAL SOURCES

	(Check all that apply)	Primary (Check only one)
2. Parents/family		
3. School		
4. County social service		
5. Information/referral service		
6. Court system/corrections		
7. Group/foster home		
8. Mental health worker		
9. Residential center		
10. Other CD treatment center		
11. Detox		
12. Friends		
13. EAP		
14. HMO		
15. Physician		
16. Other		

17. Is this a court ordered evaluation? ___ (1) No ___ (2) Yes

LIVING ARRANGEMENT *(30-day minimum)*

	Lifetime (Check all that apply)	Past Year (Check all that apply)	Primary (Check only one)	Most Recent (Check only one)
With both biological parents	18.	35.	52.	53.
With mother and step-father/parent figure	19.	36.		
With mother only	20.	37.		
With father and step-mother/parent figure	21.	38.		
With father only	22.	39.		
With adoptive parents	23.	40.		
With other relatives	24.	41.		
Boarding school	25.	42.		
Independent living	26.	43.		
With foster family	27.	44.		
In other sheltered care (temporary)	28.	45.		
In group home	29.	46.		
In residential treatment center	30.	47.		
In halfway house	31.	48.		
In jail	32.	49.		
In psychiatric unit	33.	50.		
Other	34.	51.		

FAMILY/SCHOOL

54. Is child adopted? ___ (1) No ___ (2) Yes

55. Number of siblings 0 1 2 3 4 5 6 7 8 9+

56. Is child a twin? ___ (1) No ___ (2) Yes

57. Current school status *(Check only one)*
___ (1) Currently in school
___ (2) Suspended
___ (3) Expelled
___ (4) Quit school
___ (5) Working toward GED
___ (6) Graduated from high school

58. Highest Grade Passed 1 2 3 4 5 6 7 8 9 10 11 12

HEALTH PAYMENT RESOURCES

59. Medicaid/Medicare ___ (1) No ___ (2) Yes

60. Blue Cross/Blue Shield ___ (1) No ___ (2) Yes

61. Insurance Company ___ (1) No ___ (2) Yes

62. HMO ___ (1) No ___ (2) Yes

63. Parents or self pay ___ (1) No ___ (2) Yes

64. Other ___ (1) No ___ (2) Yes

RECENT SUBSTANCE USE

(Use the following codes to indicate most recent ingestion of chemicals listed below)

1 = Within 24 hours
2 = 2-7 days ago
3 = 8-14 days ago
4 = Over 2 weeks ago
5 = Never used
6 = Undetermined

65. ___ Alcohol
66. ___ Marijuana
67. ___ Sedatives/barbiturates
68. ___ Stimulants/amphetamines
69. ___ Minor tranquilizers
70. ___ Hallucinogens
71. ___ Synthetic painkillers
72. ___ Opioids
73. ___ Cocaine
74. ___ Inhalants
75. ___ Over-the-counter drugs

76. **FAMILY INCOME**
___ (1) Less than $10,000
___ (2) $10,001 to $20,000
___ (3) $20,001 to $30,000
___ (4) $30,001 to $50,000
___ (5) Over $50,000
___ (6) Undetermined

_____ 77. ☐☐ Staff Code

Intake completed by (signature)

CATOR

ADOLESCENT HISTORY

Date ___ ___ / ___ ___ / ___ ___

ID # ___ ___ ___ / ___ ___ ___ ___

Birth Date ___ ___ / ___ ___ / ___ ___

Sex ___ (1) Male ___ (2) Female

Facility _____

Facility Code ___ ___ ___ ___

SCHOOL HISTORY

1. If in school, number of days absent in last month ☐☐

Discipline problems in past year that resulted in:

2. Being sent to principal ___ (1) No ___ (2) Yes
3. A family conference ___ (1) No ___ (2) Yes
4. A suspension ___ (1) No ___ (2) Yes
5. An expulsion ___ (1) No ___ (2) Yes
6. Being placed on probation ___ (1) No ___ (2) Yes
7. Other ___ (1) No ___ (2) Yes

8. How many times have you been caught using alcohol or drugs at school? ☐☐

9. Have you changed schools in past year? ___ (1) No ___ (2) Yes

If yes, was school change due to:

10. Graduation ___ (1) No ___ (2) Yes
11. Family move ___ (1) No ___ (2) Yes
12. Substance use ___ (1) No ___ (2) Yes
13. Other reasons ___ (1) No ___ (2) Yes

14. Have you had such a hard time reading that you couldn't keep up with your class? ___ (1) No ___ (2) Yes

15. Have you ever been diagnosed as having a learning disability? ___ (1) No ___ (2) Yes ___ (3) Don't know

Have you been in any special classes for:

16. Learning problems? ___ (1) No ___ (2) Yes
17. Behavior problems? ___ (1) No ___ (2) Yes

FAMILY SUBSTANCE ABUSE

18. Has drinking by any family member repeatedly caused family, health, job, or legal problems? ___ (1) No ___ (2) Yes

If yes, who?

19. ___ Father
20. ___ Mother
21. ___ Stepfather/parent figure
22. ___ Stepmother/parent figure
23. ___ Brother(s)
24. ___ Sister(s)
25. ___ Grandfather(s)
26. ___ Grandmother(s)
27. ___ Other family members

28. Has drug use by any family member repeatedly caused family, health, job, or legal problems? ___ (1) No ___ (2) Yes

If yes, who?

29. ___ Father
30. ___ Mother
31. ___ Stepfather/parent figure
32. ___ Stepmother/parent figure
33. ___ Brother(s)
34. ___ Sister(s)
35. ___ Grandfather(s)
36. ___ Grandmother(s)
37. ___ Other family members

GENERAL RELATIONSHIP WITH	Mostly Fight	Avoid Each Other	Get Along	Close	Not Applicable
38. Mother					
39. Father					
40. Stepmother					
41. Stepfather					
42. Siblings					

SHARE PROBLEMS WITH	No	Yes	N/A
43. Mother			
44. Father			
45. Stepmother/parent figure			
46. Stepfather/parent figure			
47. Sister(s)			
48. Brother(s)			
49. Other relatives			
50. Friends			
51. School personnel			
52. Social worker/probation officer			
53. Other(s)			

PHYSICAL/SEXUAL ABUSE HISTORY

54. Has your mother, father or stepparent ever hit you so hard or so often that you had marks or were afraid of them? ___ (1) No ___ (2) Yes

55. Has anyone else living in your household ever hit you so hard or so often that you had marks or were afraid of them? ___ (1) No ___ (2) Yes

56. Has anyone in your family ever hit anyone else in the family so hard or so often that they had marks or were afraid of that person? ___ (1) No ___ (2) Yes

57. Has a friend or anyone you dated ever forced you to have sexual contact against your wishes? ___ (1) No ___ (2) Yes

58. Have you ever had any kind of sexual contact with an authority figure, such as a teacher, doctor, employer, counselor or police officer? ___ (1) No ___ (2) Yes

59. Has any adult or older person outside the family ever touched you sexually against your wishes or forced you to touch them sexually? ___ (1) No ___ (2) Yes

60. Has any adult or older person outside the family ever tried or succeeded in having any kind of sexual intercourse with you against your wishes? ___ (1) No ___ (2) Yes

61. Has any older or stronger member of your family ever touched you sexually or had you touch them sexually? ___ (1) No ___ (2) Yes

62. Has any older or stronger member of your family ever tried or succeeded in having any kind of sexual intercourse with you? ___ (1) No ___ (2) Yes

LIFETIME STRESSORS

63. Death of a parent ____ (1) No ____ (2) Yes
64. Death of a sibling ____ (1) No ____ (2) Yes
65. Death of a close friend ____ (1) No ____ (2) Yes
66. Divorce of parents ____ (1) No ____ (2) Yes
67. Separation of parents ____ (1) No ____ (2) Yes
68. Remarriage of parent ____ (1) No ____ (2) Yes

PAST YEAR STRESSORS

69. Serious family financial problems ____ (1) No ____ (2) Yes
70. Serious injury to self ____ (1) No ____ (2) Yes
71. Serious illness in self ____ (1) No ____ (2) Yes
72. Loss of close friendship ____ (1) No ____ (2) Yes

RELIGIOUS INVOLVEMENT

73. Have you had any formal religious training (e.g., Sunday school, Confirmation instruction, Hebrew school)? ____ (1) No ____ (2) Yes
74. How long since you attended a religious service?
    - ____ (1) Over a year ago
    - ____ (2) Within last year
    - ____ (3) Within last month
75. How often do you typically attend religious services?
    - ____ (1) Never
    - ____ (2) Several times a year
    - ____ (3) 1–3 times a month
    - ____ (4) Weekly

SUBSTANCE USE/SOCIAL USE PATTERNS

76. How many of your friends use alcohol and/or drugs?
    - ____ (1) None
    - ____ (2) Less than half
    - ____ (3) About half
    - ____ (4) Over half
    - ____ (5) Most or all
77. Have you changed friends in the past year? ____ (1) No ____ (2) Yes

How often do you use during activities:

	Never	Sometimes	Usually	Always
78. At school				
79. With parents				
80. With siblings				
81. With friends				
82. With others				

How often have you been confronted about your use of alcohol or drugs by:

	Never	Sometimes	Often
83. Parents			
84. Siblings			
85. Other relatives			
86. School personnel			
87. Friends			
88. Social worker/PO			

EMPLOYMENT

89. During the school year, how many hours a week do you work at a job? ☐☐

Work Problems related to alcohol or drug use:

	No	Yes	N/A
90. Poor performance			
91. Absence or lateness			
92. Warning from employer about use			
93. Loss of a job			

CHEMICAL DEPENDENCY TREATMENT HISTORY

94. How long since last chemical dependency treatment?
    - ____ (1) No previous treatment *(skip 95-97)*
    - ____ (2) Within past month
    - ____ (3) Within past six months
    - ____ (4) Within past year
    - ____ (5) Within past two years
    - ____ (6) Over two years ago
95. Type of last chemical dependency treatment:
    - ____ (1) Inpatient
    - ____ (2) Outpatient
    - ____ (3) Other
96. Did you complete last chemical dependency treatment? ____ (1) No ____ (2) Yes
97. Did you use during last chemical dependency treatment? ____ (1) No ____ (2) Yes

MEDICAL CARE UTILIZATION

	Lifetime	Past Year	
Service Type	Times	Times	Days
Inpatient CD evaluation	98.	110.	122.
Outpatient CD evaluation	99.	111.	
Inpatient CD treatment	100.	112.	123.
Outpatient CD treatment	101.	113.	
Detox Center	102.	114.	124.
Hospital Detox	103.	115.	125.
Hospital medical admission	104.	116.	126.
Inpatient psychiatric treatment	105.	117.	127.
Outpatient psychiatric treatment	106.	118.	
ER visit for suicide attempt	107.	119.	
ER visit for accidental overdose	108.	120.	
ER visit for illness/injury	109.	121.	

During the past year, how many office visits have you made to a doctor for:

128. An injury? ☐☐
129. An illness? ☐☐
130. During the past year, how many visits have you made to any other health professionals (e.g., physical therapist, chiropractor, nurse)? ☐☐

EMOTIONAL/PSYCHOLOGICAL DIFFICULTIES

In the past year, have you frequently been troubled by:

131. Nervousness ____ (1) No ____ (2) Yes
132. Tension ____ (1) No ____ (2) Yes
133. Restlessness or irritability ____ (1) No ____ (2) Yes
134. Depression, "blues," sadness ____ (1) No ____ (2) Yes
135. Suicidal thoughts ____ (1) No ____ (2) Yes
136. Sleep problems ____ (1) No ____ (2) Yes
137. Lack of energy, easily tires ____ (1) No ____ (2) Yes
138. Have you ever had sudden attacks of panic or anxiety with physical symptoms such as shortness of breath, pounding heart or dizziness? ____ (1) No ____ (2) Yes
139. Was there ever a time that lasted at least 3 months when you starved yourself because of fear of being overweight even though others said you were already thin? ____ (1) No ____ (2) Yes
140. Was there ever a time that lasted at least 3 months when you binged on large quantities of food at least twice a week and then vomited or used laxatives to counteract the effects of the binge? ____ (1) No ____ (2) Yes
141. In the past year have you attempted to kill yourself? ____ (1) No ____ (2) Yes

SUBSTANCE USE FREQUENCY

[Place a check in the row after each chemical to indicate typical use during past year]

	None	Rarely (Less than once a month)	Monthly (1-3 times a month)	Weekly (1-5 days a week)	Daily (6-7 days a week)
142. **Alcohol**					
143. **Marijuana** Hashish					
144. **Barbiturates Sedatives** sleeping pills					
145. **Stimulants** Amphetamines speed					
146. **Tranquilizers** Valium/Librium Ativan/Xanax					
147. **Hallucinogens** LSD/PCP/dust/ acid/crystal					
148. **Painkillers** Percodan/Talwin Codeine/Demerol					
149. **Opiates** Heroin/Dilaudid Morphine					
150. **Cocaine** Crack					
151. **Inhalants** Glue/paint/gasoline					
152. **Over-the-counter drugs** Diet pills					
153. **Tobacco**					

154. In the past year, what was your longest period of not using any mood altering chemicals?

____ (1) 1-2 days
____ (2) 3-7 days
____ (3) 1-3 weeks
____ (4) 1-2 months
____ (5) 3-6 months
____ (6) over 6 months

AGE OF ONSET OF SUBSTANCE USE

155. How old were you when you started to drink alcohol? ☐☐
156. How old were you when you started to use marijuana? ☐☐
157. How old were you when you started to use any other drug? ☐☐
158. How old were you when you started smoking cigarettes (or using smokeless tobacco)? ☐☐

SUBSTANCE ABUSE SYMPTOMS

159. Do you ever drink or use drugs more than you planned? ____ (1) No ____ (2) Yes
160. Do you usually have alcohol or other drugs on hand in case you need some? ____ (1) No ____ (2) Yes
161. Do you usually use alcohol or other drugs before going out? ____ (1) No ____ (2) Yes
162. Do you prefer to go places where alcohol or other drugs are available? ____ (1) No ____ (2) Yes
163. Do you ever use alcohol or other drugs to reduce tension or get to sleep? ____ (1) No ____ (2) Yes
164. Do you ever use alcohol or drugs for pain or discomfort? ____ (1) No ____ (2) Yes
165. Does it take more alcohol or drugs to get you high than it used to? ____ (1) No ____ (2) Yes
166. Do you ever drink or use other drugs to ease a hangover or other effects from the night before? ____ (1) No ____ (2) Yes
167. Have you ever had shakes or hand tremors? ____ (1) No ____ (2) Yes
168. When using alcohol or drugs do you more often do things you know are wrong? ____ (1) No ____ (2) Yes
169. Do you ever use alcohol or drugs just before or during school? ____ (1) No ____ (2) Yes
170. Do you ever use alcohol or drugs to handle or get away from problems with your family? ____ (1) No ____ (2) Yes
171. Do you ever use alcohol or drugs so you can get a feeling of belonging with your friends? ____ (1) No ____ (2) Yes
172. Do you consider yourself chemically dependent? ____ (1) No ____ (2) Yes

SELF-IMAGE	Rarely	Some-times	Often	Usually
173. Do you take good care of yourself physically?				
174. Do you like the way you look?				
175. Do you consider yourself attractive?				
176. Do you respect yourself?				
177. Are you ashamed of yourself?				
178. Do you hate yourself?				
179. Do you feel like killing yourself?				
180. Do your parents respect you?				
181. Are your parents ashamed of you?				
182. Do your friends respect you?				
183. Do your parents love you?				

SEXUAL ACTIVITY

184. Are you sexually active? ____ (1) No ____ (2) Yes

185. If yes, are you more sexually active since you began using alcohol or drugs? ____ (1) No ____ (2) Yes

186. If you are sexually active, do you use birth control?

____ (1) Never
____ (2) Sometimes
____ (3) Usually
____ (4) Always

187. Have you ever (been pregnant) (gotten anyone pregnant)? ____ (1) No ____ (2) Yes

LEGAL INVOLVEMENT

188. How many times have you ever been in trouble with the law? ☐☐

189. Age at first trouble? ☐☐

190. How many times have you ever been arrested? ☐☐

191. Age when arrested the first time? ☐☐

Number of arrests in past year:

192. DWI arrest? ☐☐

193. Other misdemeanor arrest? ☐☐

194. Felony arrest? ☐☐

195. In the **past year** how many times were you ticketed or arrested for possession or use of alcohol? ☐☐

196. In the **past year** how many times were you ticketed or arrested for possession or use of drugs? ☐☐

197. Were you arrested for a status offense in the **past year**? ____ (1) No ____ (2) Yes

198. Was an out of control petition **ever** filed by parent or guardian? ____ (1) No ____ (2) Yes

As a result of an arrest have you ever been:

199. Put into a detox center? ____ (1) No ____ (2) Yes

200. Given an informal reprimand? ____ (1) No ____ (2) Yes

201. Given an informal hearing? ____ (1) No ____ (2) Yes

202. Put on probation? ____ (1) No ____ (2) Yes

203. Required to make restitution? ____ (1) No ____ (2) Yes

204. Put in a detention center? ____ (1) No ____ (2) Yes

205. Put in jail overnight? ____ (1) No ____ (2) Yes

206. In an out of home placement? ____ (1) No ____ (2) Yes

207. Placed in a juvenile corrections facility? ____ (1) No ____ (2) Yes

208. Given a jail sentence? ____ (1) No ____ (2) Yes

209. Certified as an adult or waived into adult court? ____ (1) No ____ (2) Yes

Do you have any current charges pending for:

210. Status offense? ____ (1) No ____ (2) Yes

211. Misdemeanor? ____ (1) No ____ (2) Yes

212. Felony? ____ (1) No ____ (2) Yes

Are you currently under the supervision of a:

213. Probation officer? ____ (1) No ____ (2) Yes

214. Social worker? ____ (1) No ____ (2) Yes

Driving history

215. Do you now have a valid driver's license? ____ (1) No ____ (2) Yes

216. Have you ever had a valid driver's license? ____ (1) No ____ (2) Yes

217. Has your license ever been suspended or revoked? ____ (1) No ____ (2) Yes

218. In the **past year** how many times have you had an accident while driving under the influence? (cars, motorbikes, snowmobiles, etc.) ☐☐

219. How many moving vehicle accidents were you involved in as a passenger in the **past year**? ☐☐

_____ 220. ☐☐
Interview completed by (signature) **Staff Code**

CATOR

ADOLESCENT DISCHARGE

Discharge Date ___ ___ / ___ ___ / ___ ___

ID # ___ ___ ___ / ___ ___ ___ ___

Birth Date ___ ___ / ___ ___ / ___ ___

Sex ___ (1) Male ___ (2) Female

Facility _____

Facility Code ___ ___ ___ ___

LEVEL OF SUBSTANCE USE

[Use following codes to indicate level of use for each substance type]

1 = No use
2 = Experimental use
3 = Regular use
4 = Abuse
5 = Dependence
6 = Undetermined

1. ___ Alcohol
2. ___ Marijuana/hashish
3. ___ Sedatives/barbiturates
4. ___ Stimulants/amphetamines
5. ___ Minor tranquilizers
6. ___ Hallucinogens
7. ___ Synthetic painkillers
8. ___ Opioids
9. ___ Cocaine
10. ___ Inhalants
11. ___ Over-the-counter drugs
12. ___ Other substances

SYMPTOMS OF SUBSTANCE ABUSE

[Use the following codes to indicate presence of symptom for each substance]

1 = No 2 = Yes 3 = Undetermined

	Alcohol	Marijuana	Cocaine
Preoccupation/anticipation	13.	33.	53.
Chemicals on hand	14.	34.	54.
Daily use	15.	35.	55.
Binges	16.	36.	56.
Morning use	17.	37.	57.
Use alone	18.	38.	58.
Attempts to limit use	19.	39.	59.
Inability to stop	20.	40.	60.
Blackouts/amnesia	21.	41.	61.
Use as medicine	22.	42.	62.
Injury/illness	23.	43.	63.
Social/interpersonal impairment	24.	44.	64.
Legal problems	25.	45.	65.
Increased tolerance	26.	46.	66.
Decreased tolerance	27.	47.	67.
Withdrawal signs	28.	48.	68.
Personality changes	29.	49.	69.
Value changes	30.	50.	70
School problems	31.	51.	71.
Family problems	32.	52.	72.

OTHER PROBLEM AREAS	Not a Problem	Reported Prior to Treatment	Found During Treatment	Undetermined
73. Psychiatric disorder				
74. Learning disability				
75. Eating disorder				
76. Physical abuse				
77. Sexual abuse				
78. Suicidal ideation				

TREATMENT STATUS

79. Length of inpatient stay ☐☐☐ (days)

80. Length of outpatient services ☐☐☐ (contact hours)

81. Discharge status
- ___ (1) Evaluation only
- ___ (2) Full discharge — completed program
- ___ (3) Behavioral discharge
- ___ (4) Discharged against staff advice
- ___ (5) Other

82. Was patient caught using during treatment? ___ (1) No ___ (2) Yes

DISCHARGE REFERRALS/RESIDENTIAL *(Check only one)*

83. ___ Parental home
84. ___ Other relative's home
85. ___ Halfway house/extended care
86. ___ Inpatient CD or psychiatric program
87. ___ Group home/foster home
88. ___ Correctional facility

DISCHARGE REFERRALS/ADJUNCT *(Check all that apply)*

89. ___ Aftercare
90. ___ AA/NA
91. ___ Alateen/Alanon
92. ___ Other support group
93. ___ Individual counseling/therapy
94. ___ Family counseling/therapy

FAMILY PARTICIPATION	None	Partial	Full	N/A
95. Mother				
96. Father				
97. Stepmother/parent figure				
98. Stepfather/parent figure				
99. Foster parents				
100. Other guardian				
101. Sister(s) (Stepsisters)				
102. Brother(s) (Stepbrothers)				

SUBSTANCE ABUSE BY	No	Suspected	Yes, Active	Recovering	Not Known	N/A
103. Mother						
104. Father						
105. Stepmother/parent figure						
106. Stepfather/parent figure						
107. Sister						
108. Brother						
109. Other household member						

REFERRALS FOR OTHER FAMILY MEMBERS

110. ___ Chemical dependency assessment/treatment

111. ___ Psychiatric/psychological referral

112. CONSENT SHEET SIGNED ___ (1) No ___ (2) Yes

_____ 113. ☐☐
Discharge completed by (signature) Staff Code

Adolescent Problem Severity Index

APSI

ADMINISTRATION

MANUAL

January 1991

David S. Metzger
Harvey Kushner
A. Thomas McLellan

Biomedical Computer Research Institute
Philadelphia, Pa.

THE ADOLESCENT PROBLEM SEVERITY INDEX (APSI)

The APSI is a structured screening interview. It has been designed to help professionals identify and respond to adolescent problems that may require intervention. In all, seven areas of functioning are evaluated: 1) Legal, 2) Family Relationships, 3) Educational/Work, 4) Medical, 5) Psycho/Social Adjustment, 6) Drug/Alcohol Use, and 7) Personal Relationships. Additionally, there are sections for documenting identifying information about the youth, their guardians and other involved adults; the reason for referral; and, summary information about the interview. In each area there is ample space to make notes and additional comments. By asking all of the questions and accurately recording the responses as described on the form, sufficient information should be available to make a determination regarding the need for additional intervention.

Please keep in mind that the APSI is not a substitute for professional judgement nor is it a short cut to decision making in difficult situations. It is a tool that must be used properly in order to be effective. This manual is intended to be a quick reference guide for those who have completed a training session and it should answer many questions that arise in the course of conducting interviews.

STARTING THE INTERVIEW

1. INTRODUCE THE ADOLESCENT PROBLEM SEVERITY INDEX

Every interview should begin with a brief, clearly worded introduction. It's important that those present at the start of the interview understandf what is about to take place. The interviewer should introduce all those present and briefly explain the purpose of the interview by giving an overview of the areas to be covered and the amount of time required for completion. To help make the interview go as quickly as possible be sure to tell the adolescent that part of your job is to make sure that all the questions are asked and that you may have to stop some discussion and move things along. For example:

> *Before we start I'd like to make sure you understand what is going to happen here. In order to be sure that I have a complete picture of your situation, I am going to be asking alot of questions about your involvement with the police, family situation, your school, your health, your emotional status, your drug and alcohol use and your personal relationships. The more we know about your situation, the more we will be able to help.*
>
> *This usually takes about 45 minutes to an hour to finish. I won't be able to get into alot of detail now. There just isn't enough time. I may even have to stop you from talking about some things to make sure we get to everything.*

2. PARTICIPATION IN THE INTERVIEW

The interview is best completed with the adolescent alone. Parents, however, have the right to be present during interviews such as this and may not allow a private interview. If this is the case, ask if the parents would be willing to be present for just the first five sections: legal, family, education, medical, and psycho-social adjustment. Then explain that you would like to interview their son or daughter privately about drug and alcohol use, and personal relationships. It is our experience that parents are quite willing to cooperate when fully informed. If the parents are reluctant or unwilling to leave during any part of the interview, we encourage the interviewer to go ahead and administer the whole interview with the parents present.

> *Mr. and Mrs. Jones, we have found that these interviews go better when its just me and the adolescent so I will need to have time alone with John to talk with him . O.K.? Good. Before you leave however, could you give me some information about yourselves and others involved with John.*

If the parents or guardians insist on being present, your instructions might sound like this:

> *John, your parents said that they would like to be here during the interview but I'd like you to do most of the talking. Mr. and Mrs. Jones, I would like the two of you to participate as needed during the first part of this interview. Then, I will need to have some time alone with John to talk with him about his drug and alcohol use and his personal relationships. O.K.?*

After completing the general information section, questions should be directed at the adolescent. Keep in mind that this is not a parent interview. While we have found that parents can add useful information (particularly in the school and medical area), we want the adolescent's self report of how they are doing in the seven target areas.

3. IMPORTANCE OF TRUTHFULNESS AND ACCURACY

The interviewer should explain that the goal is to obtain information which is as accurate as possible. will help us identify possible problem areas and their severity. Explain to the youth, that if there is a question that cannot answer truthfully, we would rather have him/her not answer the question rather than make up an answer.

> *John, I'm going to be asking you many questions and some of them are very personal. It is important that you give truthful and accurate information. The reason for asking these questions is not to punish you, it is so I can decide what is best for you. If you cannot tell me the truth about a certain subject, I would rather have you give no answer. So, if you can't answer truthfully, just say you don't want to answer it, O.K.?*

4. CONFIDENTIALITY

It is very important that interviewers discuss issues of confidentiality with those present. While policies on the use of information will vary from setting to setting, participants should clearly understand who will have access to the information. The personal nature of the information requested during the interview, demands that all responses be treated with the greatest degree of respect and

When I'm done here I will be writing a report that will summarize our discussion. It will be used in processing your case and determining our response. Only the agency staff and other professionals the court feels would benefit from this information will have access to the report. You should also know that should you tell me about dangerous situations, I will take action to make sure the danger is removed.

HOW TO CONDUCT THE APSI INTERVIEW

1. ASK QUESTIONS WHICH REQUIRE THE ADOLESCENT TO THINK AND RESPOND WITH A FULL SENTENCE

The interviewer's goal should be to engage the youth in a **conversation** about different problem areas. We have found that adolescents are likely to get into a response pattern if questions are asked in manner which allows them to only answer with a "*yes*" or "*no*". It is critical that the interviewer feel free to probe further at any point and ask questions which will improve the accuracy and precision of the response. Please keep in mind that too many questions will

2. PROBE WHEN NECESSARY

An interviewer may choose to ask for more specific information when he/she gets an affirmative or incomplete response to an item. Keep in mind that the interview is like a script. At times, however, the interviewer may need to ask a question out of order to improve the flow of the information.

3. MAKE NOTES AND COMMENTS

As you are obtaining information about different problem areas, be sure to mark your responses so they can be used later. If your using the C.A.S.E. software, all responses will need to be clear for data entry. Make notes that detail the youth's responses. Its important to do this during the interview. Interviewers should record information in the "Comments Section", found at the end of each section.

The "Comments" section can also be used for the interviewer to write his or her own conclusions or thoughts about this youth's functioning in that particular problem area. These comments can add a great deal to the quality of the CASE report.

ASSESSING THE NEED FOR ADDITIONAL INTERVENTION

Severity ratings are extremely important to the overall effectiveness of the APSI. These ratings represent the interviewers assessment of the need for additional intervention in each area.

Severity ratings range from 0 to 3. A score of 0 would indicate no need for additional intervention. A score of 1 would suggest a minor or potential problem which needs to be monitored. A severity rating of 2 would indicate a serious problem requiring treatment or further professional assessment. The highest severity rating is a 3 and indicates a need for immediate intervention.

Severity ratings should be made at the close of questionning in each section. All critical items (numerical responses enclosed in shaded squares) should be reviewed briefly paying particular attention to non-zero items. The interviewer must feel free to use their judgement when arriving at the severity ratings. All information (both objective and subjective) should be used in arriving at a severity score. For example, a juvenile living with a substance abusing parent may not report many indicators of family problems but may be perceived by the interviewer as having a need for counseling. In this case, the interviewer should assign a severity score of 2 indicating a need for professional assessment. Comments explaining this decision should be added to the section.

Another possible scenario would be the situation in which an individual has emotional problems that are already being adequately treated. In this situation, the composite score, the sum of the box items, may be high while the severity score is relatively low. If you are using the automated CASE software for the APSI, please note that your severity rating will determine the recommendation that is printed--regardless of the responses to individual items.

COMPOSITE SCORES

A second type of score is able to be produced for each section of the APSI. These scores are called composite scores and provide a simple quantitative measure of the indicators of problems in each area of assessment. Higher scores indicate that more reports of problems of problems were provided by the adolescent. Although this score should correlated with the severity rating, this is not necessarily the case. Given the fact that the APSI is a new form, the composite scores do not yet have norms. Thus, absolute values must be interpreted cautiously.

The APSI has been designed to be easily scored by hand. To generate a composite score, simply add all the numbers that appear in boxes for the section being scored. There is only one exception to this rule and that is found in item 3 of the Drug/Alcohol section. For this item you simply add the highest row value for alcohol, the highest row value for marijuana, and the highest row value from all other substance groups. Three boxes are found at the end of item 3 for these values.

GENERAL INFORMATION SECTION

This section is designed to obtain basic identifying information about the youth, his or her current guardians, and involved others. This information can be collected prior to the actual interview. While this may save time, some interviewers prefer to gather this information themselves. Asking these questions as part of the interview, provides a non-threatening way of interacting with the juvenile and can help establish rapport prior to moving into the body of the interview. Other interviewers (who may be pressured by time constraints) prefer to allow their clerical staff to obtain this basic information from the juvenile and guardians prior to the interview.

The general information section consists of four parts. The four parts obtain information about: (1) the juvenile; (2) current guardians; (3) other household members; and, (4) other involved adults

Current guardians are the adults who are responsible for the welfare of the adolescent. These may or may not be the legal guardians. Extensive information is requested about each guardian which will facilitate contacting them in the future should that be necessary.

Other household members are those living in the home, such as sisters, brothers, step-siblings, half-siblings, friends, boarders, other relatives, etc. The purpose of this item is to obtain a picture of the numbers, ages, and relationship of the people living in the household.

Information is also collected for other involved adults. This may include any significant adult not previously mentioned. This adult need not reside in the household with the juvenile. For example, if information has already been collected about the youth's mother and stepfather with whom he/she lives, then the "Other Involved Adults" section provides an opportunity to ask for information about the natural father. In another circumstance, this section would provide the chance to record information about a caretaking adult who is not a guardian of the youth. There is ample space for comments which can be used to provide greater detail about issues of guardianship and supervision.

THE LEGAL SECTION

Item 1 DRIVER'S LICENSE This item asks if the youth has ever had a driver's license. If yes, the license number should be placed in the space provided and the adolescent should be asked if their license has ever been suspended or revoked for any reason, this should also be checked in the appropriate box. In some states, driving privileges can be delayed if the youth is charged with certain offenses (eg. underage drinking) prior to getting a license. In the APSI this is referred to as having the license postponed. Space is provided to record the reason for these actions.

Item 2 SUMMARY OFFENSE The interviewer should ask if the adolescent has ever been charged with a summary offense such as truancy and if so, the number of times this has occurred. Summary offenses are sometimes referred to as status offenses.

Item 3 ADJUDICATED DELINQUENT The interviewer should next ask if the adolescent has ever been found guilty by a juvenile court and if so, the number of times this has occurred..

Item 4 JUVENILE DISPOSITION EVER? In some areas charges to which adolescents admit involvement, are handled without direct court involvement. The APSI refers to these as informal adjustments. The interviewer should ask if the adolescent has ever received a juvenile disposition such as an informal adjustment or consent decree and if so, the number of times this has occurred.

Item 5 PAST CHARGES/FOUND NOT GUILTY The interviewer should ask if the youth has ever been charged with a crime (including summary offenses) and been found not guilty, and how many times this has occurred.

Item 6 QUESTIONED BUT NOT CHARGED The interviewer asks if the youth has ever been questioned by authorities about a crime but not charged, and how many times this has occurred.

Item 7 CURRENT CHARGES The interviewer must determine if there are any current charges facing the adolescent. These charges may stem from recent behaviors that have not yet been resolved.

Item 8 LIST OF CHARGES Space is provided for the interviewer to list the specific charges, their date and type. This item should be completed in order to provide some documentation of the specific nature of the charges identified in the prior items.

The following legal items are completed only for those who have had police contact:

Item 9 AGE WHEN FIRST CHARGED The interviewer must determine the age of the youth at the time of their first police contact, whether or not this contact resulted in a conviction. Then the interviewer must record in the box the correct number of the corresponding age group.

Item 10 A. DETENTION CENTER EVER? The interviewer determines if the youth has ever spent time in a detention center. If the youth responds in the affirmative, the interviewer should note number of separate detention center placements and the number of days in a detention center during the past year.

Item 10 B. JUVENILE PROBATION The interviewer indicates if the youth has ever been on probation. Although it is not requested on the form, the interviewer should request more details if the youth has been on probation in the past.

Item 10 C. WEAPON TAKEN This item asks if the youth has ever had a weapon taken away from him/her. This includes any kind of weapon (even nonlethal) removed by anyone. For example, this might include a policeman taking away a handgun, or a teacher taking away a penknife, or a parent taking away a B.B. gun. Again, it is important to collect sufficient details of any such incidents and add these to the comments section.

As in all sections of the APSI, this section ends with the completion of additional comments. .

THE FAMILY RELATIONSHIPS SECTION

The family relationships section is designed to obtain an overview of the adolescent's relationships with other family and household members. As is true with all sections of the APSI, these questions serve as a starting point. While many of the questions and answers will prompt further inquiry on the part of the interviewer, please keep in mind that this is not the time to begin treatment. If additional pertinent information is gathered, it should be recorded in the "Comments" area found at the end of the section.

Item 1 HOUSEHOLD MEMBERS Put a check next to each person currently living in the youth's household. List the number of brothers, sisters, stepbrothers, and stepsisters living in the household. Space is provided for recording the ages of siblings and stepsiblings. List any additional household members by relationship to the youth i.e. mother's boyfriend, paternal uncle, maternal grandmother, father's friend, boarder.

Item 2 PARENTAL STATUS Check the box which describes the current marital status of the youth's parents. If either parent is deceased, record the age of the juvenile when their parent died.

Item 3 CHANGE IN LIVING ARRANGEMENTS The purpose of this question is to find out if there has been a major change in living situation in the past year. If yes, place a 1 in the box provided. A "major change" can take many forms. Some possible examples follow: 1) In the past year, the youth has had a significant disruption in living arrangements.requiring that he/she live elsewhere. This might refer to a foster care or group home placement, or even to staying with a relative. The duration must exceed 2 nights and 2 days. It would not refer to planned vacations; 2) In the past year, the family has moved from one location to another; 3) In the past year, a family member has left the household i.e. parents separated, brother went to college, aunt moved in with the family.

Item 4 DISSATISFIED If the youth is dissatisfied or unhappy with their current living arrangement for any reason, place a 1 in the box. The interviewer should attempt to determine the exact reason for the displeasure..

Item 5 YOUTH OUT OF HOME IN PAST Answer "Yes" if the youth has had to live away from parents or primary guardians. If yes, record the number of times this has occurred. Space is provided for the specification of four such arrangements. For example:

1. Grandmother's house 1978 1 year 6 mnths.

This would indicate that the youth lived with his grandmother for one and one half years beginning in 1978.

Item 6 SIBLING EVER OUT OF HOME Place a 1 in the box if any sibling has ever lived out of the home before they turned eighteen.

Item 7 RUNAWAY Place a 1 in the box if the youth has ever run away or was thrown out regardless of the length of time out of the home. Runaway is defined as an intentional act on the part of the youth to leave their guardians, without their permission.

Item 8 ARGUING/FIGHTING IN HOME This item asks for the youth's opinion of whether there is a lot of arguing or fighting in the home. If the youth is unsure how to answer, ask them to describe how many times a day a major argument takes place. Also it's a good idea to attempt to determine the degree to which the youth is bothered by the arguing. This can help the adolescent to guage the level of conflict in the home.

THE TEMPORAL SCALE

Items 9 and 10 These items and many others in later sections of the APSI require the interviewer to establish whether the event in question is a past problem (more than one month ago=1), a current problem (occurring during the past month=2), or an ongoing problem (during the past month and before=3). This is best accomplished by first asking if this event has ever occurred. If it has, then the interviewer should determine whether the event occurred within the month prior to the interview or if it occurred before the prior month. If the event in question took place during both periods of time, then the interviewer record this as a 3 in the block.

Item 9 A ARREST This item refers to the arrest of any family member or nonfamily household member. Therefore, it would include the arrest of a transient household member. It would not include the arrest of a temporary visitor. Space is provided to allow four individuals to be listed.

Item 9 B HOSPITALIZED This item refers to the hospitalization of any member of the household due to serious illness, injury, psychiatric problem, or drug/alcohol treatment. Situations of this nature can be very traumatic. Space is provided to allow four individuals to be listed.

Item 9 C DEATH Record whether any family or household member has died, and if so whether this death took place recently. This item refers to all household members, familial and non-familial. Space is provided to allow four individuals to be listed.

Items 10A to 10C probe serious conflicts and confrontation with household members. It is possible that instances of physical or sexual abuse will surface. Be aware of your office policy regarding response to reports of abuse.

Item 10 A. SERIOUS PROBLEM GETTING ALONG This item requests the opinion of the youth being interviewed. A "serious" problem is one which "bothers" the youth and which he/she would like to be rid of. Normal sibling conflict should not be included. Using the temporal scale, indicate the adolescent's response in the block.

Item 10 B. PHYSICAL FIGHT Answer "Yes" if the youth has had a confrontation involving physical aggression with either parent, guardian, or adult household member. If the physical confrontations are taking place with an adult, the issue of physical abuse must be evaluated (see discussion in square above.) Using the temporal scale, indicate the adolescent's response in the block.

Item 10 C. FAMILY COUNSELING/CASEWORKER This item provides an indication of the family's involvement with counseling or social welfare agency. Using the temporal scale, indicate the adolescent's response in the block.

THE EDUCATION/WORK SECTION

The education/work section is designed to collect information on the behavioral and academic performance of the youth. Most of the questions in this section are self-explanatory, often requiring a "Yes" or "No" response to a specific behavioral question. The interviewer is asked to consider each question for each youth regardless of whether or not they are currently in school. If an adolescent is not currently enrolled in school the questions should be asked in reference to their most recent school experience.

CURRENTLY ENROLLED IN SCHOOL? The interviewer is asked to determine if the youth is currently enrolled in school. If it is summer and the youth has every intention of returning to school in the Fall, the answer is "yes."

PAST MONTH ATTENDANCE Three categories of attendance are used in this item--Regular; Sporadic; and None. Regular attendance should be checked if there have been less than four absences (for any reason) during the preceding month. Sporadic should be checked if there have been four or more absences during the preceding month. None should be checked if there has been no school attendance. Leave the item blank if it is summer recess.

Item 1 CURRENT/LAST SCHOOL Please record the name and address of the current or last school attended.

Item 2 HIGHEST GRADE COMPLETED Circle the number which corresponds to the highest grade completed; if the youth has completed his/her GED, then circle "12." If the youth has any post-high school education, circle the "plus" sign.

Item 3 SPECIAL PROGRAMMING The question refers to specific school based programs in which the youth is enrolled. This may include, but is not limited to special education programs for learning disabilities (LD), for socially and emotionally disturbed students (SED), high school equivalency preparation programs (GED), home bound instruction, vocational/technical school (VOTECH), etc.

Item 4 AVERAGE GRADES If a youth seems to have trouble answering this question, the interviewer may assist by asking what grades they received on their last report card.

Item 4A FAILING CLASSES Place a 1 in the box if the youth believes that he/she is failing or in danger of failing a class. Failure of a single test or project is not sufficient to respond "Yes".

Item 5 CLASS FAILURE/LAST YEAR Place a 1 in the box if the youth failed a subject on their report card during the prior year.

Item 6 GRADE FAILURE Place a 1 in the box if the youth has ever had to repeat a grade; then circle the grade which was failed. If the youth has failed the same grade twice, please record this.

Item 7 TOTAL a.) SUSPENSIONS AND b.) EXPULSIONS Place a 1 in the box if the youth has ever been suspended or expelled from school; including current episodes. Then record the number of total suspensions or expulsions.

Item 8 CURRENTLY SUSPENDED/EXPELLED Place a 1 in the box if the youth is currently suspended or expelled from school.

Item 9 PLAN TO GRADUATE/GED? Check "Yes" if the youth states that they intend to finish high school or to get GED.

Items 10 A-C These items require that the interviewer first establish whether the behavior in question has EVER happened in the youth's lifetime. Once that has been determined, the interviewer can then ask whether these behaviors have occurred in the past month.

Item 10 A SKIPPED SCHOOL/CUT CLASSES This item probes whether the youth has ever missed a school-day without the permission of his/her parents, or whether he/she admits to any unexcused absences from class **more than once in the same week.**

Item 10 B PARENTS CALLED BY SCHOOL This item asks whether a parent or guardian has been called by any school personnel to discuss the youth's behavior. This includes informal calls of concern from a teacher, or a more formal call from the disciplinarian.

Item 10 C SERIOUS ARGUMENT/FIGHT WITH TEACHER This item probes whether the youth has acted on their anger with school personnel. A serious argument would be one which the youth identifies readily as "serious."

Item 11 WORKING? This question should be asked regardless of school status. Any paid regularly scheduled employment should be considered.

Item 12 WORK HISTORY Use the grid provided to record the job titles, dates of employment, and reason for leaving for every job held by the youth. For informal jobs such as lawnwork, or babysitting it is sufficient to record the title of the job and the dates involved.

Item 13 EVER FIRED Indicate whether the youth has ever been fired from a job, and the reasons why.

Item 14 JOB SKILLS OR TRAINING Please indicate whether the youth believes that he/she has any skills or training that could help him/her obtain a job.

Item 15 YOUTH'S NET WEEKLY INCOME Record the net (take home) weekly income which the youth receives from all sources, employment and otherwise.

Item 16 INCOME SOURCES Record all sources of income which come directly to the youth. Parental income is assessed elsewhere, so that this item refers only to income which the youth receives directly.

THE MEDICAL SECTION

The questions in the medical section will provide the interviewer with a general sense of the youth's state of health. The information provided can assist in determining if medical evaluation by a physician is indicated.

Item 1 LAST PHYSICAL EXAM Record in months how long it has been since the youth had his/her last physical examination by an M.D.

Item 2 CHRONIC MEDICAL PROBLEMS Answer "Yes" if the youth has a medical condition which which requires ongoing monitoring or treatment (e.g. medication, dietary restrictions.) For example, asthma, hypertension, diabetes, epilepsy, and serious physical handicaps would be considered chronic conditions.

Item 3 PRESCRIBED MEDICATIONS NOW? Answer "Yes" if the youth is taking prescribed medications. They must be prescribed by a physician for this youth. Record the name of the medication, and it's purpose.

Item 4 EMERGENCY ROOM/PAST YEAR? Answer "Yes" if the youth has used the services of a hospital emergency room in the past year. Record the reason for the visit.

PSYCHO-SOCIAL ADJUSTMENT

Item 1 TREATMENT FOR EMOTIONAL PROBLEM Answer "Yes" if the youth has ever been treated or evaluated by a professional for a psychological or emotional problem. This could include evaluation or treatment offered by any number of professionals in a variety of settings. For example, it could include psychological evaluation at a mental health center, emergency psychiatric evaluation at a hospital emergency room, evaluation for SED placement by a school psychologist, or outpatient individual treatment for psychiatric symptoms. It would not include family therapy. List the name of the professional who provided the evaluation or treatment, the location, and if possible the diagnosis or problem identified.

Item 2 A through F: This series of items probes whether the youth has experienced feelings or thoughts that are commonly seen as symptoms of psychological distress. In most cases, the youth will know what the interviewer is talking about when symptoms are described using common terms. At times, the interviewer may have to provide examples to explain the feeling, thought, or behavior. Since all of these emotions are normal under certain circumstances, it's important to probe in order to determine if the feelings are related to events or situations in which the emotion being assessed is appropriate. Interviewers should determine the duration and frequency of occurrance of the symptom--symptoms lasting for several days or those that are frequently recurring need to be evaluated. All of these items should be recorded using the temporal scale.

Item 2A. VERY UNHAPPY, SAD, OR DEPRESSED?
Item 2B. WORRIED, AFRAID, SCARED?
Item 2C. LONELY, ALL ALONE, ISOLATED?
Item 2D. SENSE OF FAILURE?
Item 2E. TROUBLE CONTROLLING YOUR ANGER?
Item 2F. TROUBLE FALLING ASLEEP OR STAYING ASLEEP?
Item 2G. APPETITE CHANGE OR WEIGHT CONCERN?

Item 3 SERIOUS THOUGHTS OF HURTING SELF? This item probes whether the youth has ever experienced thoughts of harming him/herself.

If the youth indicates that they have had thoughts of harming themself, the interviewer must obtain further information to evaluate if the youth is at risk of acting on those thoughts. This determination should be performed by or in consultation with a trained mental health professional

It is important that the interviewer probe and evaluate affirmative responses in order to determine the nature and seriousness of the self-destructive thinking. Frequently people experience a sense of relief when they can speak with another person about their thoughts of hurting themselves or of suicide. The goal of the interviewer is to determine if the youth has ever experienced serious thoughts of suicide. The interviewer should make an effort to determine the severity of these thoughts. **If the interviewer discovers that the youth being interviewed has seriously considered harming themself or of suicide in the past month, the youth should be immediately referred for professional evaluation. If unsure about whether or not to refer the youth to an expert for evaluation, it is best to refer the youth.**

Item 3 A TROUBLE MAKING OR KEEPING FRIENDS The youth is asked to indicate whether they have ever had trouble making or keeping friends.

Item 3 B GIRLFRIEND/BOYFRIEND PROBLEMS The youth is asked to indicate generally whether he/she has had serious problems with a girlfriend/boyfriend. For this question, "seriousness" is determined by the youth.

Item 3 C FEELS NO-ONE REALLY CARES This item probes whether the youth feels alone, unwanted, and unloved.

Item #3D IN TROUBLE BECAUSE OF FRIENDS This item probes whether the youth has a history of getting into trouble "because" of friends.

DRUG AND ALCOHOL USE

Item 1 (A through C) HOW MANY OF YOUR FRIENDS SMOKE CIGARETTES/DRINK ALCOHOL/DO DRUGS? This item is self-explanatory. When asking it, the interviewer should offer the categories to the youth, as in a multiple choice question, e.g. "How many of the people you hang out with smoke cigarettes--some, none, or all of them?" The youth can then indicate which category is correct. The response to this question may be an indicator of the acceptability of substance use within peer group in which the youth is involved.

Item#2 CIGARETTE USE Record whether the youth smokes cigarettes , and if so, indicate how old he/she was at the onset of regular smoking habit (smoking three or more days in a week).

Item 3 DRUG AND/OR ALCOHOL USE CHART: AGE AT ONSET/ USE PAST YEAR/ USE PAST MONTH

For completing this chart, it is recommended that the interviewer first ask "*How old were you when you first used alcohol*?" The interviewer should phrase the question in such a way that there is an implicit acceptance of the fact that the youth may have used alcohol. We believe that this phrasing is very important in helping adolescents feel more comfortable in reporting past use. The interviewer should then proceed by asking "*How many times have you used alcohol in the past year?*" Finally, the interviewer concludes by asking "*How many times would you say that you used alcohol in the past month*?" **For our purposes, a time of use is a day in which that substance has been consumed in any quantity.** The youth may require assistance in figuring out how many times he/she has used a substance in the past year. The interviewer can feel free to assist the youth in making the calculations. Many youth have a general idea of how often they use a substance over the course of a week or month, but no idea of how frequently they use it in a year. The interviewer can help figure out yearly frequency by obtaining the pattern and frequency of weekly or monthly use and multiplying by fifty two or twelve. It is not necessary to arrive at a precise count. As indicated on the form, use is coded into three broad categories. With regard to the substances, interviewers must be aware of the various drug classes and their specific substances. It is not appropriate to ask a youth if they have ever used "depressants". Give examples of the types of drugs that fall into the depressant category, especially those known to be available and used in the area. The final drug class on the APSI is blank. This is included to provide an opportunity for probing for any additional substance use that may not have been identified in the listed items. Any such substance use should be detailed in the comments section.

Items 4A-4D. SOCIAL INDICATORS OF DRUG/ALCOHOL USE
These items are asked only for those who indicate that they have used alcohol or drugs in item 3. Using the temporal scale these items screen for indication of disruptions in daily life caused by substance use (either drug or alcohol).

4 A. and B. This item asks the extent to which drug and/or alcohol use has been incorporated into the youth's day to day activities at school or work.

4 C. This item asks whether others including peers have suggested a reduction in substance use.

4 D. This item asks whether the youth has ever been enrolled in any type of program for drug and/or alcohol treatment. Drug and Alcohol education are not to be included in this item. Nor should peer counseling programs be included, unless attendance resulted from a referral by a substance abuse professional.
#4 e. This item asks whether the youth has ever gotten into any kind of trouble while using drugs or alcohol. Intoxication is not necessary.

Item 5A-5D. AVAILABILITY These items are asked of everyone--even those who have denied use.

5 A. and B. The temporal scale is used here to probe youth's attendance at parties where alcohol and drugs were available. The term "party" refers to any gathering.

5C. This item asks if the youth has ever been accused of being high or intoxicated, even if the accusation was false.

5D. This item asks if the youth has ever been in a car (a common location for adolescent substance use) when drug and alcohol use took place.

Item 6 A to C PEERS AND DRUG/ALCOHOL
6 A. This item asks whether the youth has ever been asked to get drugs or alcohol for friends. Friends are defined as individuals with whom the youth spends time (hangs out with).

6 B. This item asks whether the youth has ever felt pressured into using drugs or alcohol.

6 C. This item asks whether any friends have ever been treated for substance abuse problems.

Item 7 MONEY SPENT ON ALCOHOL/DRUGS PAST MONTH Record, in the spaces provided, the dollar amount spent on drugs and/or alcohol in the past month. This item provides another way of probing the extent of the youth's drug and/or alcohol involvement as reported in item 3. There should be a correlation between the extent of drug and/or alcohol use and the amount of money spent on these substances. If there is any discrepancy, the interviewer should probe and question in order to get a clear sense of actual drug/alcohol use and expenses.

Items 8 and 9 . FAMILY AND DRUG/ALCOHOL USE These three items require a simple Yes or No answer. They probe whether the youth believes that the mother, father, or any other household member has a drug and/or alcohol problem.

Item 10 This item asks whether the youth is allowed to use alcohol or drugs in the home. It is not meant to include small amounts of alcohol used under adult supervision on special occasions. It attempts to identify those youth who live in families where underage drug and/or alcohol use is tolerated, expected, or encouraged.

PERSONAL RELATIONSHIPS

The personal relationships section aims to obtain some basic information about the youth's involvement in and knowledge about unsafe sexual behavior. This section can be difficult for interviewers due to the private nature of the questions asked. We have found it most helpful to introduce the section by telling the youth that we are going to be discussing personal relationships, and that this will include questions about sexual behavior. When introduced in a matter-of-fact manner, most youths are quite willing to talk about these issues.

Item 1 SERIOUS RELATIONSHIP YES/NO? This item opens up the topic of discussion by probing whether the youth has ever had a girlfriend or boyfriend relationship.

Item #2 SERIOUS RELATIONSHIP CURRENTLY? The answer to this item establishes whether the youth is currently involved in a serious relationship from his or her perspective. The youth is the judge of what is a "serious" relationship.

Item 2A DISSATISFIED WITH CURRENT RELATIONSHIP? This item asks whether or not the youth is satisfied with this current relationship.

Item 3 HAD SEXUAL INTERCOURSE EVER?
This item simply probes if the youth has yet experienced sexual intercourse.

Item 4 SEX WITHOUT BIRTH CONTROL EVER?
This item probes whether or not the youth has engaged in sexual behavior without taking precautions to avoid unwanted pregnancy.

Item 5 DIFFICULT TO PROTECT SELF FROM UNWANTED PREGNANCY OR SEXUALLY-TRANSMITTED DISEASE? This item probes whether the youth is aware of ways to avoid unwanted pregnancy or sexually-transmitted diseases, and whether he/she is able to utilize this knowledge.

Item 6 EVER TREATED SEXUALLY-TRANSMITTED DISEASE This item determines whether the youth has ever contracted and obtained treatment for a sexually transmitted disease.

Item 7 EVER TAUGHT HOW TO AVOID GETTING AIDS? Record whether or not the youth reports being taught about how to avoid exposure to HIV.

HOW CAN SOMEONE AVOID GETTING AIDS? This item probes the extent of the youth's knowledge about the transmission of the AIDS virus.

Items 8 PHYSICAL/SEXUAL ABUSE This item asks the youth to report if they have ever been physically or sexually abused. The interviewer must be familiar with the definitions of abuse and their office's policy regarding response to abuse. If abuse is reported the interviewer must indicate whether or not it was formally investigated. An explanation of the incident must be included.

Item 9 CONSIDERED CALLING POLICE? This item asks if the youth has ever considered calling the police because of the behavior of other household members. This provides an opportunity for the youth to discuss difficult, potentially abusive home situations. If Yes, an explanation should be written.

Item 10 PRESSURED INTO SEX? This item provides an additional probe regarding potential sexual abuse. For younger children, the question is posed in 10a. as "Have you ever been touched in a way you didn't like?" This is familiar language for many children. Again, any affirmative response must be explained in detail and properly reported.

Item 11 CURRENT STATUS If item 8, 9, 10, or 10a. are answered Yes, the interviewer must determine if the youth is currently in situations where these behaviors continue. If Yes, the interviewer must determine who is involved. It is imperative that abusive situations be reported to the proper authorities and the immediate safety and welfare of the youth be completely evaluated.

Adolescent Problem Severity Index
APSI Version 1.0

Section I: General Information

Date: __/__/__ Case Number:_____

Interviewer:_____

1. Name: _____

Current Address:

_____

_____

_____

Phone Number (___)_____-_____

2. Sex ☐ Male ☐ Female

3. Race (check only one)
- ☐ White (not of Hispanic origin)
- ☐ Black (not of Hispanic origin)
- ☐ Hispanic - ☐Mexican - ☐Puerto Rican - ☐Cuban
- ☐ American Indian
- ☐ Asian or Pacific Islander
- ☐ Other _____

4. Age ____

5. Date of birth: (mm/dd/yy) ___/___/___

6. S.S. #: ____-___-____

7. Do you wear eye glasses? ☐Yes ☐No

8. Height ___ft.___in.

9. Hair Color:_____

10. Weight ____lbs. 11.Eye Color _____

12. Other Distinguishing Features:

_____

_____

13.Medical Coverage: ☐Yes ☐No
Plan:_____

Policy #:_____

Current Guardians

Name: _____
Relationship: _____
Address: _____

_____

Phone Number: (___)_____-_____
Age:_____ Date of Birth:___/___/___
S.S. #: _____
Occupation: _____
Employer: _____
Work Address: _____

_____

Work Hours: _____
Work Phone: _____
Gross Income/month:_____

Name: _____
Relationship: _____
Address: _____

_____

Phone Number: (___)_____-_____
Age:_____ Date of Birth:___/___/___
S.S. #: _____
Occupation: _____
Employer: _____
Work Address: _____

_____

Work Hours: _____
Work Phone: _____
Gross Income/month:_____

Other Household Members:

Name	Age	Relationship
_____	____	_____
_____	____	_____
_____	____	_____
_____	____	_____

Other Involved Adults

Name: _____

Relationship: _____

Address: _____

_____

Phone Number: (____)_____-_____

Age:_____ Date of Birth:____/____/____

S.S. #: _____

Occupation: _____

Employer: _____

Work Address: _____

_____

Work Hours: _____

Work Phone: _____

Name: _____

Relationship: _____

Address: _____

_____

Phone Number:(____)_____-_____

Age:_____ Date of Birth:____/____/____

S.S. #: _____

Occupation: _____

Employer: _____

Work Address: _____

_____

Work Hours: _____

Work Phone: _____

Comments

Section II: Reason For Assessment

1. Referral Source Information

Person making referral:_____ Position_____

Agency:_____ Phone Number: (___)-_____-_____

Address:_____ FAX Number: (___)-_____-_____

_____

_____

_____

2. Reason for Interview:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

3. Adolescent's Understanding of Reason for Interview:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

4. Other Available Documentation:

a._____ e._____

b._____ f._____

c._____ g._____

d._____ h._____

Section III: Legal

1. Do you have a drivers license? ☐No ☐Yes Operator's Number#:_____

If Yes, have your driving privileges ever been:

a. Postponed 0=No 1=Yes ☐
Explain:_____

b. Suspended 0=No 1=Yes ☐
Explain:_____

c. Revoked 0=No 1=Yes ☐
Explain:_____

2. Have you ever been convicted of a summary offense? 0=No 1=Yes ☐
If yes, how many times?_____

3. Have you ever been adjudicated delinquent by a juvenile court? 0=No 1=Yes ☐
If yes, how many times?_____

4. Have you ever received an alternative juvenile disposition? 0=No 1=Yes ☐
If yes, how many times?_____

5 Have you ever been charged with a crime (including summary offenses)
and been found not guilty ?: 0=No 1=Yes ☐
If yes, how many times?_____

6. Have you ever been questioned about a crime by the authorities but not charged? 0=No 1=Yes ☐
If yes, how many times?_____

7. Are you currently facing charges or awaiting a hearing? 0=No 1=Yes ☐

8. CHARGES	DATE	1=Summary Offense 2=Adjudicated Delinquent 3=Alternative Disposition 4=Found Not Guilty 5=Current charge/pending
a._____	__/__/__	____
b._____	__/__/__	____
c._____	__/__/__	____
d._____	__/__/__	____
e._____	__/__/__	____
f._____	__/__/__	____
g._____	__/__/__	____
h._____	__/__/__	____
i._____	__/__/__	____
j._____	__/__/__	____

If question 2 thru 7 = YES, complete items 9 and 10.

9. How old were you at the time of your first police contact? _____yrs. ❑

Age 15 to 18 = 1
Ages 13 and 14 =2
Under age 13 =3

10. Have you ever:

A. Spent time in a detention center?

0=No 1=Yes ❑

If yes, how many separate incidents:_____
How many days in past year?____

B. Been on juvenile probation?

0=No 1=Yes ❑

C. Had a weapon taken away from you?

0=No 1=Yes ❑

Do you feel that you have a legal problem ?

0=No 1=Yes ❑

If yes, would you like help in dealing with your legal problem ?
❑ No ❑Yes

INTERVIEWER SEVERITY RATING:
How would you rate this adolescent's need for additional legal help?

○

No Need =0
Minor Need =1
Moderate Need =2
Urgent Need =3

Comments About Legal Issues

Section IV: Family Relationships

1. With whom do you currently live: (check all that apply)
   - ❑ Mother ❑ Father
   - ❑ Stepmother ❑ Stepfather
   - ❑ Sister(s)#___: ages___:___:___:___
   - ❑ Stepsister(s)#___: ages___:___:___:___
   - ❑ Brother(s)#___: ages___:___:___:___
   - ❑ Stepbrother(s)#___: ages___:___:___:___
   - ❑ others: a._____b._____
   - c._____d._____

2. If not living with both natural parents, are they (currently)?
   - ❑ Divorced
   - ❑ Separated
   - ❑ Never Married
   - ❑ Deceased

   If either parent(s) are deceased, how old were you at the time of their death?
   - ❑ Mother:_____
   - ❑ Father:_____

3. Has your living arrangement changed in the past year?

   0=No 1=Yes ❑

4. Are you unhappy or dissatisfied with the current situation at home?

   0=No 1=Yes ❑

5. Have you ever had to live away from your home and parents/current guardians?:

   0=No 1=Yes ❑ Number of Times:_____

   5a. If yes, where did you live? (e.g. relative's home, foster home, detention center)

Where	When(yr.)	Length(yy/mm)
1._____		/___
2._____		/___
3._____		/___
4._____		/___

6. Have any of your brothers or sisters ever had to live away from home before they were eighteen years old?

   0=No 1=Yes ❑

7. Have you ever run away from home?

   0=No 1=Yes ❑ If yes, how many times_____

8. Is there a lot of arguing or fighting in your house?

   0=No 1=Yes ❑

9. Has any member of your family or household ever :

   0=No
   1=More than a month ago
   2=In the past month
   3 In the past month and before

   A. ❑ been arrested? Who:
   a._____
   b._____
   c._____
   d._____

   B. ❑ been hospitalized due to life threatening illness, injury, or treatment for psychiatric, drug or alcohol problems?
   Who:
   a._____
   b._____
   c._____
   d._____

   C. ❑ died? Who:
   a._____
   b._____
   c._____
   d._____

10. Have you ever:
    0=No 1=More than a month ago 2=During the past month 3=During the past month and before

    A. ❑ had serious problems in getting along with anyone in your household?

    B. ❑ had a physical fight with either of your parents/guardians?

    C. ❑ been involved in family counseling, or had a caseworker assigned to visit your family?

Do you feel that you have a family problem ?

0=No 1=Yes ☐

If yes, would you like counseling for these family problems?
☐Yes ☐No

INTERVIEWER SEVERITY RATING:
How would you rate this adolescent's need for additional family counseling?

○

No Need =0
Minor Need =1
Moderate Need =2
Urgent Need =3

Comments About Family Relationships

Section V: Education/Work

Are you currently enrolled in school? ☐Yes ☐No
Past Month Attendance: ☐Regular ☐Sporatic (4+ absences) ☐None

1. Current or last school attended
   School Name:_____

   Address:_____
2. Current or highest grade completed: (Circle One)
   1 2 3 4 5 6 7 8 9 10 11 12 +
3. Are (did) you receiving any special programming
   0=No 1=Yes ☐
   Type of Program: _____
4. On average, what are (were) your grades? (Circle One)
   A B C D F
   4a. Are you failing any classes?
   0=No 1=Yes ☐
5. Did you fail any classes last year?
   0=No 1=Yes ☐
6. Have you ever failed or repeated a grade?
   0=No 1=Yes ☐
   6a. Which grade(s)? (Circle)
   1 2 3 4 5 6 7 8 9 10 11 12
7. Have you ever been suspended or expelled (include in school suspensions) ?
   a. Suspended b. Expelled
   0=No 1=Yes ☐ ☐
   #____ #____
8. If yes, are you currently suspended or expelled?
   Suspended Expelled
   0=No 1=Yes ☐ ☐
9. Do you plan on graduating (or getting a GED) ?
   ☐Yes ☐No
10. Have you ever:
    0=No 1=More than a month ago 2=During the past month 3=During the past month and before
    A. ☐ Skipped school or cut classes more than one time in one week?
    B. ☐ Had your parents called by the school because of your behavior?
    C. ☐ Had a serious argument or fight with a teacher?
11. Are you working now?
    ☐Yes ☐No
    If yes, how many hours per week?_____
12. Work History (Current job First) :

Job	Dates	Reason for Leaving
A._____		
B._____		
C._____		
D._____		
E._____		

13. ☐ Have you ever been fired from a job?
    1=yes 0=No
    If yes, Why?_____
14. Do you have any skills or training that could help you get a job? ☐Yes ☐No
    If yes, what skills?_____
15. Income per week (Net): $_____
16. Current Source(s) of Income:
    - ☐ Social Security
    - ☐ Public Assistance
    - ☐ Parent
    - ☐ Job
    - ☐ Other_____

Do you feel that you have an school or work problem?
0=No 1=Yes ☐
If yes, would you like counseling for these school problems?
☐Yes ☐No

INTERVIEWER SEVERITY RATING:
How would you rate this adolescent's need for additional educational or vocational counseling?

○

No Need =0
Minor Need =1
Moderate Need =2
Urgent Need =3

Comments About Education/Work

Section VI: Medical

1. How long ago was your last physical examination? _____(months)

2. Do you have any chronic medical problems (eg.: diabetes, asthma, allergies)? 0=No 1=Yes ☐
   If yes, what condition?_____

3. Are you taking any prescribed medication at this time? 0=No 1=Yes ☐
   If yes, what medication?_____

4. Have you had to visit an emergency room in the past year? 0=No 1=Yes ☐
   If yes, how many times:_____ Why? :_____

Do you feel that you have any medical problems?

0=No 1=Yes ☐

If yes, would you like treatment for your medical problem?
☐Yes ☐No

INTERVIEWER SEVERITY RATING:
How would you rate this adolescent's need for additional medical treatment? ○

No Need =0
Minor Need =1
Moderate Need =2
Urgent Need =3

Comments About Medical Issues

Section VII: Psycho/Social Adjustment

1. Have you ever been treated for an emotional problem by a psychiatrist, psychologist, or other counselor?

0=No 1=Yes ☐

Seen by:_____

Of:_____

_____

2. Has there ever been a time (a few days or more) when you have :

0=No
1=More than a month ago;
2=During the past month;
3=During the past month and before

A. ☐ felt very unhappy; sad; depressed?

B. ☐ felt worried; afraid; scared ?

C. ☐ felt very lonely; all alone; isolated?

D. ☐ felt like a failure or worthless?

E. ☐ had trouble controlling your anger?

F. ☐ had trouble falling or staying asleep?

G. ☐ lost your appetite or worried about your weight?

3. Have you ever had serious thoughts of hurting yourself? ☐

3a. If yes, have you ever attempted suicide? ☐

If yes, how long ago?:_____

4. Have you ever :

0=No; 1=More than a month ago; 2=During the past month; 3=During the past month and before

A. ☐ had trouble making or keeping friends

B. ☐ serious problems with girlfriend/boyfriend

C. ☐ felt like no one really cared about you?

D. ☐ gotten into trouble because of your friends?

Do you feel that you have emotional problems?

0=No 1=Yes ☐

If yes, would you like treatment for your emotional problems?

☐Yes ☐No

INTERVIEWER SEVERITY RATING:
How would you rate this adolescent's need for additional psychological treatment ? ○

No Need =0
Minor Need =1
Moderate Need =2
Urgent Need =3

Comments About Psycho/Social Issues

Section VIII: Drug/Alcohol Use

1. How many of the people you hang out with (spend time with):

	NONE	SOME	ALL
....*Smoke*	*0*	*1*	*2*
.....*Drink*	*0*	*1*	*2*
...*Do Drugs*	*0*	*1*	*2*

2. Do you smoke cigarettes?

0=No 1=Yes ☐

If yes, how old were you when you starting smoking regularly? (three or more times a week) _____

3.	Age First Used:				Times Used Past Year				Times Used Past Month			
	No	15-18	12-14	<12	0	1-5	6-20	>20	0	1-3	4-8	>8
Alcohol	0	1	2	3	0	1	2	3	0	1	2	3
Marijuana	0	1	2	3	0	1	2	3	0	1	2	3
Cocaine	0	1	2	3	0	1	2	3	0	1	2	3
Crack	0	1	2	3	0	1	2	3	0	1	2	3
Inhalants	0	1	2	3	0	1	2	3	0	1	2	3
Speed	0	1	2	3	0	1	2	3	0	1	2	3
Depressant	0	1	2	3	0	1	2	3	0	1	2	3
Hallucin.	0	1	2	3	0	1	2	3	0	1	2	3
Other:	0	1	2	3	0	1	2	3	0	1	2	3

Composite Scoring: *Highest Row Value: Alcohol* ☐ *Marijuana* ☐ *All others* ☐

If no drug or alcohol use is reported in #3, skip to question #5.

Use following rating scale for items 4, 5, and 6.
0=No
1=More than a month ago;
2=During the past month;
3=During and before the past month

4. Have you ever:

A. ☐ used drugs or alcohol before or during school?

B. ☐ missed school (or ☐ work) because you were high or hung over?

C. ☐ been told you that you should cut down or stop using drugs or alcohol?

D. ☐ been in a program to get help for a drug or alcohol problem?

E. ☐ gotten into trouble (including this incident) for things you have done while you were using drugs or alcohol?

5. Have you ever:

A. ☐ been at a party where alcohol was served?

B. ☐ been at a party where drugs were available?

C. ☐ been accused by your parents, teachers, or employer of being drunk or high?

D. ☐ been in a car where the driver or others were using alcohol or drugs?

6. Have any of your friends:

A. ☐ ever asked you to get drugs or alcohol for them?

B. ☐ ever tried to get you to drink or use drugs?

C. ☐ ever been treated for drug or alcohol problems?

7. How much money would you say you spent during the past month on: Alcohol$_____Drugs $_____

8. Do either of your parents now have (or have they ever had) a drug or alcohol problem?

MOTHER: 0=No 1=Yes ☐ FATHER: 0=No 1=Yes ☐

9. Do any other members of your household have a drug or alcohol problem? 0=No 1=Yes ☐ Who?_____

10. Are you permitted to drink at home (*excluding small amounts on special occasions*) ? 0=No 1=Yes ☐

Do you feel that you have drug/alcohol problems?

0=No 1=Yes ❑

Would you like treatment or counseling for these problems?

❑Yes ❑No

INTERVIEWER SEVERITY RATING:
How would you rate this adolescent's need for additional drug or alcohol counseling?

○

No Need =0
Minor Need =1
Moderate Need =2
Urgent Need =3

Comments About Drug/Alcohol Use

Section IX: Personal Relationships

1. Have you ever had a serious relationship (boyfriend or girlfriend)? ☐Yes ☐No

2. Are you currently involved in a serious relationship? ☐Yes ☐No

   A. If yes, are you unhappy or dissatisfied with this relationship? ☐ 1=Yes 0=No

3. Have you ever been sexually active (had sexual intercourse)? ☐ 1=Yes 0=No *(If no skip to question 7)*

4. Have you ever had sex without taking precautions to avoid unwanted pregnancy? 1=Yes 0=No ☐

5. Is it difficult for you to always protect yourself from unwanted pregnancy or sexually transmitted diseases?
   ☐ 1=Yes 0=No

6. Have you ever had a sexually transmitted disease (gonorrhea, clap, VD, etc.)? ☐ 1=Yes 0=No

7. Have you been taught about how to avoid getting AIDS? ☐Yes ☐No
   Can you tell me how someone can avoid getting AIDS? ☐Yes ☐No
   (If yes,Check all Mentioned leave blank if not reported)
   ☐ Use condoms ☐ don't have sex ☐ don't share needles
   ☐ Don't Know ☐ Incorrect Response ☐ other:_____

8. Have you ever been ☐physically or ☐sexually abused? ☐ 1=Yes 0=No
   If yes, was the incident investigated? ☐Yes ☐No
   Explain:_____

9. Have you ever seriously considered calling the police because of the way members of your household were acting? 0=No 1=Yes ☐
   Explain:_____

10. Have you ever been forced or pressured into having sex when you did not want to? 0=No 1=Yes ☐

    10a. If no, have you ever been touched in a way that you didn't like? 0=No 1=Yes ☐
    Explain:_____

11. If 8, 9, 10 or 10a is Yes, are you <u>currently</u> in a relationship where this is happening? ☐ 1=Yes 0=No
    Explain:_____

Would you like more information or help in dealing with these concerns?

0=No 1=Yes ☐

INTERVIEWER SEVERITY RATING:
How would you rate this adolescent's need for information or counseling?

○

No Need =0
Minor Need =1
Moderate Need =2
Urgent Need =3

Section X: Profile

1. SEVERITY PROFILE

	0	1	2	3
LEGAL	☐	☐	☐	☐
FAMILY	☐	☐	☐	☐
EDUCATION	☐	☐	☐	☐
MEDICAL	☐	☐	☐	☐
PSY/SOC. ADJ.	☐	☐	☐	☐
SUBSTANCE USE	☐	☐	☐	☐
PERSONAL	☐	☐	☐	☐

2. Guardian Assessment*

	Agree	Disagree
LEGAL	☐	☐
FAMILY	☐	☐
EDUCATION	☐	☐
MEDICAL	☐	☐
PSY/SOC. ADJ.	☐	☐
SUBSTANCE USE	☐	☐
PERSONAL	☐	☐

* Relationship of Rater:

3.OVERALL CONFIDENCE RATINGS:

Do you feel the information is significantly distorted by:

A.. Client's misrepresentation? ☐ Yes ☐ No B..Client's inability to understand? ☐ Yes ☐ No

4. How long did this interview last? _____minutes

Summary Comments

Comprehensive Addiction Severity Index For Adolescents

(CASI-A)

Kathleen Meyers

Center for Studies of Addiction
University of Pennsylvania/
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Philadelphia, PA 19104

COMPREHENSIVE ADDICTION SEVERITY INDEX FOR ADOLESCENTS (CASI-A)

FACE SHEET

I.D. NUMBER ☐☐☐☐

DATE OF ADMISSION (month/day/year) ☐☐☐☐☐☐

DATE OF INTERVIEW (month/day/year) ☐☐☐☐☐☐

TIME BEGUN ☐☐ ☐☐

TIME ENDED ☐☐ ☐☐

CLASS ☐

1 - Intake (Baseline)
2 - Retest
3 - Follow-up

SPECIAL ☐

1 - Subject terminated
2 - Subject unable to respond/understand
3 - Possible misrepresentation

TEST RESULTS

Verbal I.Q. ☐☐☐

Performance I.Q. ☐☐☐

Full Scale I.Q. ☐☐☐

URINE DRUG SCREEN RESULTS

USE THE FOLLOWING CODE:

0 - Negative Sample, <u>did not</u> contain metabolites of drug
1 - Positive, <u>did</u> contain metabolites of drug
2 - Quantity was insufficient for a test
3 - Was not tested
X - Patient refused to submit sample

ITEM	DRUG TYPE	VALUE
1	Methadone	☐
2	Other Opiates (morphine, heroin, codeine)	☐
3	Amphetamine (biphetamine, methamphetamine)	☐
4	Cocaine (in any form)	☐
5	Barbiturates (phenobarbital, pentobarbital)	☐
6	Benzodiazepines (Oxazepam, Diazepam, Alprazolam)	☐
7	Other sedative hypnotics (Chloral Hydrate)	☐
8	Nicotine	☐
9	Marijuana (THC in any form)	☐
10	Inhalants (toluene, other solvents)	☐
11	Hallucinogens (LSD, PCP, MDMA)	☐
12	Other (_____)	☐

ALCOHOL BREATHALYZER READING ☐☐

(Enter the blood alcohol level directly from the breathalyzer report; e.g., .10, .00, .09, etc.)

Note: The period has already been inserted, just enter the numbers that follow the period.

Insert **NN** if no reading was asked for.
Insert **XX** if patient refused breathalyzer.

COMMENTS

GENERAL INFORMATION

Name _____

Current address _____

_____

Phone number _____

1 - Gender
- 1 - Male
- 2 - Female

2 - Race
- 1 - White (not of Hispanic origin)
- 2 - Black (not of Hispanic origin)
- 3 - American Indian
- 4 - Asian or Pacific
- 5 - Hispanic
- 6 - Other _____

3 - Age

4 - Date of birth (month/day/year)

5 - Marital status
- 1 - Single (never married)
- 2 - Married
- 3 - Separated
- 4 - Divorced
- 5 - Widowed

6 - Number of children

7 - Religion currently practicing
- 1 - Protestant
- 2 - Catholic
- 3 - Jewish
- 4 - Islam
- 5 - Other _____
- 6 - None

8 - Have you been in a controlled environment in the past month?

1 - No
2 - Jail
3 - Alcohol/Drug treatment
4 - Medical treatment
5 - Psychiatric treatment
6 - Youth shelter
7 - Other _____

9 - Number of days in past month in a controlled environment

10 - Referral source

1 - Self
2 - Family
3 - School
4 - Professional
5 - Division of Youth and Family Services
6 - Court
7 - Other _____

11 - Time (in months) since last comprehensive physical examination

(Do not include a sports physical as a comprehensive physical examination)

11a- For Females

Time (in months) since last gynecological examination

FOR ITEMS 12 - 15 COMPLETE THE FOLLOWING:

Have you experienced ____?

0 - No
1 - Yes

How old were you when this first occurred?

Did this occur during the past year? [Answer separately for past month and other 11 months.]

0 - No
1 - Yes

How about during the past month?
0 - No
1 - Yes

	EVER	AGE FIRST	PAST 11 MONTHS	YEAR PAST MONTH
12 - A catastrophic, disabling, or life-threatening illness or injury to yourself or someone close to you	☐	☐☐	☐	☐
13 - Rejection by someone close to you	☐	☐☐	☐	☐
14 - The death of someone close to you	☐	☐☐	☐	☐
15 - Relocation/change of schools	☐	☐☐	☐	☐
16 - Other _____	☐	☐☐	☐	☐

COMMENTS

EDUCATION

IS THE SUBJECT CURRENTLY ENROLLED IN SCHOOL AND CURRENTLY ATTENDING SCHOOL?

☐ No

☐ Yes - Complete Section I

IS THE SUBJECT CURRENTLY NOT ENROLLED IN SCHOOL OR CURRENTLY NOT ATTENDING SCHOOL? (DO NOT INCLUDE SUMMER VACATION)

☐ No

☐ Yes - Complete Section II

I. CURRENTLY ENROLLED IN SCHOOL AND CURRENTLY ATTENDING SCHOOL

1 - Current grade level ☐☐

2 - Grade(s) repeated ☐☐ ☐☐ ☐☐
[Record specific grade(s)]

3 - Reason(s) for repeating grade(s) ☐ ☐ ☐
1 - Academic
2 - Attendance
3 - Both
4 - Other _____

FOR ITEMS 4 - 9 COMPLETE THE FOLLOWING:

Have there ever been significant periods during which you ___?
0 - No
1 - Yes

How old were you when this first occurred?

Did this occur during the past year? [Answer separately for past month and other 11 months.]
0 - No
1 - Yes

How about during the past month?
0 - No
1 - Yes

	EVER	AGE FIRST	PAST YEAR 11 MONTHS	PAST YEAR PAST MONTH
4 - Attended remedial class/school (Do not include gifted class/school)	☐	☐☐	☐	☐

	EVER	AGE FIRST	PAST 11 MONTHS	PAST YEAR PAST MONTH
5 - Academic problems Had failing grades, difficulty learning, paying attention and/or comprehending material	☐	☐☐	☐	☐
6 - Attendance problems Cut school/classes and/or arrived late/ left early (unauthorized) on a consistent basis	☐	☐☐	☐	☐
7 - Disciplinary problems Were suspended, expelled, had numerous detentions, violated school rules, your parents/guardians were contacted regarding disciplinary issues	☐	☐☐	☐	☐
8. - Motivation/attitude problems Had little or no interest in school, refused to complete assignments/home-work, seriously contemplated dropping out of school	☐	☐☐	☐	☐
9 - Educational intervention Met regularly with a school psychologist/ guidance counselor/social worker for reasons other than career counseling	☐	☐☐	☐	☐

10 - Do you have a marketable skill or trade? ☐
- 0 - No
- 1 - Yes

List ☐

11 - Approximately how many minutes do you typically spend on homework each day? ☐☐☐

12 - High school education ☐
- 1 - Plan to complete
- 2 - Plan to obtain GED
- 3 - Do not plan to complete
- 4 - Unsure

13 - Future plans
1 - Post high school education
2 - Work
3 - Military
4 - Undecided
5 - No plans
6 - Other _____

14 - Do you think that you have any problems with education or school?
0 - No
1 - Maybe
2 - Definitely

15 - In the past month, how often have you experienced issues with education or school which bothered you?
0 - Never
1 - Occasionally
2 - Almost every day
3 - Daily

FOR ITEMS 16 - 17 PLEASE ASK SUBJECT TO USE THE SUBJECT'S RATING SCALE

16 - Have you been troubled or bothered by any education or school-related issues?

17 - Is counseling/treatment in this area important to you?

CONFIDENCE RATINGS

Is the above information significantly distorted by:

18 - Subject's misrepresentation?
0 - No
1 - Yes

19 - Subject's inability to understand?
0 - No
1 - Yes

II. NOT CURRENTLY ENROLLED IN SCHOOL OR NOT CURRENTLY ATTENDING SCHOOL (DO NOT INCLUDE SUMMER VACATION)

1 - Highest level of education completed

2 - Number of months since last in school ☐☐

3 - Reason not in school ☐
1 - Graduated
2 - Dropped out
3 - Expelled
4 - Medical circumstances
5 - Psychiatric circumstances
6 - Drug/alcohol circumstances
7 - Legal circumstances
8 - Refusal to attend
9 - Other _____

4 - Grade(s) repeated ☐☐ ☐☐ ☐☐
[Record specific grade(s)]

5 - Reason(s) for repeating grade(s) ☐ ☐ ☐
1 - Academic
2 - Attendance
3 - Both
4 - Other _____

FOR ITEMS 6 - 11 COMPLETE THE FOLLOWING:

Have there ever been significant periods during which you ___?
1 - No
2 - Yes

How old were you when this first occurred?

Did this occur during the 11 months prior to your disenrollment (D.E.) from school or your not attending school?
0 - No
1 - Yes

How about during the month prior to your disenrollment (D.E.) from school or your not attending school?
0 - No
1 - Yes

	EVER	AGE FIRST	11 MO. PRIOR D.E.	MO.PRIOR TO D.E.
6 - Attended remedial class/school (Do not include gifted class/ school)	☐	☐☐	☐	☐
7 - Academic problems Had failing grades, difficulty learning, paying attention and/ or comprehending material	☐	☐☐	☐	☐

	EVER	AGE FIRST	11 MO. PRIOR D.E.	MO.PRIOR TO D.E.
8 - Attendance problems Cut school/classes and/or arrived late/left early (unauthorized) on a consistent basis	☐	☐☐	☐	☐
9 - Disciplinary problems Were suspended, expelled, had numerous detentions, violated school rules, your parents/ guardians were contacted regarding disciplinary issues	☐	☐☐	☐	☐
10 - Motivation/attitude problems Had little or no interest in school, refused to complete assignments/homework, seriously contemplated dropping out of school	☐	☐☐	☐	☐
11 - Educational intervention Met regularly with a school psychologist/guidance counselor/ social worker for reasons other than career counseling	☐	☐☐	☐	☐

12 - Do you have a marketable skill or trade? ☐
- 0 - No
- 1 - Yes

List _____

13 - High school education ☐
- 1 - Plan to complete
- 2 - Plan to obtain GED
- 3 - Do not plan to complete
- 4 - Unsure

14 - Future plans ☐
- 1 - Post high school education
- 2 - Work
- 3 - Military
- 4 - Undecided
- 5 - No plans
- 6 - Other _____

15 - Do you think that you have any problems with your educational status? ☐
- 0 - No
- 1 - Maybe
- 2 - Definitely

16 - In the past month, how often have you experienced issues with your educational status which bothered you? ☐

0 - Never
1 - Occasionally
2 - Almost every day
3 - Daily

FOR ITEMS 17 - 18 PLEASE ASK SUBJECT TO USE THE SUBJECT'S RATING SCALE

17 - Have you been troubled or bothered by any education or school-related issues? ☐

18 - Is counseling/treatment in this area important to you? ☐

CONFIDENCE RATINGS

Is the above information significantly distorted by:

19 - Subject's misrepresentation? ☐

0 - No
1 - Yes

20 - Subject's inability to understand? ☐

0 - No
1 - Yes

COMMENTS

SUBSTANCE USE

FOR ITEMS 1 - 15 COMPLETE THE FOLLOWING:

Have you ever used ____?
0 - No
1 - Yes

How old were you when you first tried ____?

How old were you when you first started using ____ on a regular basis?

In the past year, what was your typical (TYP) pattern of use? (Use codes in Appendix D)

In the past year, what was your most frequent pattern of use, i.e., your peak pattern? (Use codes in Appendix D)

For how long did you use _____ in this way? (Answer in weeks)

In the past month, how many days did you use ____?

How long have you used _____?

In the past year, when you have used _____, how often did you get super high (or, for alcohol, super drunk)? (Use codes in Manual)

When you use _____, with whom do you typically use? [C] (Use codes in Appendix E)

Why do you use _____? [R] (Use codes in Appendix F)

SEE MANUAL FOR REPRESENTATIVE EXAMPLES OF EACH DRUG CLASS.

	EVER	AGE FIRST	AGE 1ST REGULAR USE	PAST YR PATTERN TYP	PAST YR PATTERN PEAK	PAST MO. (# DAYS)	DURATION OF USE YEARS	DURATION OF USE MONTHS	SUPER HIGH/ DRUNK	C	R
1 - Tobacco (# cigs/day ____)	☐	☐☐	☐☐	☐	☐	☐☐	☐☐	☐☐		☐	☐

	EVER	AGE FIRST	AGE 1ST REGULAR USE	PAST YR PATTERN TYP	PAST YR PATTERN PEAK	PAST MO. (# DAYS)	DURATION OF USE YEARS	DURATION OF USE MONTHS	SUPER HIGH/ DRUNK	C	R
2 - OTC drugs _____											
3 - Alcohol											
Length of Peak Pattern											
4 - Cannabis											
Length of Peak Pattern											
5 - Cocaine-Intranasal											
Length of Peak Pattern											
6 - Cocaine-Freebase											
Length of Peak Pattern											
7 - Cocaine-Crack											
Length of Peak Pattern											
8 - Cocaine-I.V.											
Length of Peak Pattern											
9 - Amphetamines											
Length of Peak Pattern											
10 - Barbiturates/Sedatives											
Length of Peak Pattern											

	EVER	AGE FIRST	AGE 1ST REGULAR USE	PAST YR PATTERN TYP	PAST YR PATTERN PEAK	PAST MO. (# DAYS)	DURATION OF USE YEARS	DURATION OF USE MONTHS	SUPER HIGH/ DRUNK	C	R
11 - Inhalants											
Length of Peak Pattern											
12 - Hallucinogens											
Length of Peak Pattern											
13 - Opiates											
Length of Peak Pattern											
14 - Other_____ (include steroids)											
Length of Peak Pattern											
15 - Drugs intravenously (I.V.) (regardless of specific drug)											

16a- First drug used I.V. (Use Appendix G code) ☐

16b- Drugs used I.V. in the past year ☐

16c- Other drugs used I.V. ☐

17a- First substance used (Use Appendix G codes) ☐

17b- Circumstance first use (Use Appendix E codes) ☐

17c- Reason first use (Use Appendix F codes) ☐

18a- If 17a is tobacco, record second substance used (Use Appendix G codes) ☐

18b- Circumstance of use (Use Appendix E codes) ☐

18c- Reason for use (Use Appendix F codes) ☐

19 - How many days in the past 30 did you use anything?

PAST MO (# DAYS) ☐☐

20 - Overall duration of substance use (excluding tobacco)

YEARS ☐☐ MONTHS ☐☐

21 - Drug of choice (Use Appendix G codes)

PAST 11 MONTHS ☐☐ PAST MONTH ☐☐

FOR ITEMS 22 - 32 COMPLETE THE FOLLOWING:

Have there ever been significant periods during which you ____?
0 - No
1 - Yes

How old were you when this first occurred?

Did this occur during the past year? [Answer separately for past month and other 11 months.]
0 - No
1 - Yes

How about during the past month?
0 - No
1 - Yes

For which substances did this occur during the past year? (Use Appendix G codes)

	EVER	AGE FIRST	PAST YEAR 11 MONTHS	PAST MONTH	SUBSTANCES
22 - **High risk behaviors** Continued to use a substance while doing something high risk or physically dangerous, e.g., driving, swimming, boating	☐	☐☐	☐	☐	
23 - **Physical/social/psychological consequences** Had accidents or been injured when using substances, had repeated arguments with family, friends and/or authority figures because of substance use, or psychological problem was worsened (or caused) by your use of substances	☐	☐☐	☐	☐	
24 - **Preoccupation** Spent a great deal of time in activities necessary to obtain, ingest or recover from substance	☐	☐☐	☐	☐	
25 - **Interference/neglect** Attended activities (e.g., school) when using substances, missed activities due to substance use or did not participate in family or social activities due to substance use	☐	☐☐	☐	☐	
26 - **Activities given up** Consistently used substances instead of going to school or doing things you used to do with your family or friends	☐	☐☐	☐	☐	
27 - **Tolerance** Had to do more of a substance than in the past to obtain the same effect or used the same amount of a substance without obtaining the same previous effect	☐	☐☐	☐	☐	

	EVER	AGE FIRST	PAST 11 MONTHS	PAST YEAR MONTH	SUBSTANCES
28 - **Withdrawal** Experienced withdrawal symptoms when you cut down or tried to control your use of substances	☐	☐☐	☐	☐	☐
29 - **Relief of withdrawal** Used substances to avoid withdrawal symptoms	☐	☐☐	☐	☐	☐
30 - **Control** Wanted to cut down, stop using or control your use of substances but were unsuccessful	☐	☐☐	☐	☐	☐
31 - **Larger amounts** Taken substances in larger amounts or over a longer period of time than you originally intended	☐	☐☐	☐	☐	☐
32 - **Compulsive use** Felt an overpowering need to use substances, felt enslaved to substances, felt substances controlled your life, focused almost exclusively on substances, experienced a strong desire or sense of compulsion to use substances	☐	☐☐	☐	☐	☐

FOR ITEMS 33 - 35 COMPLETE THE FOLLOWING:

Have you ever had significant periods in which you _____ in order to obtain substances?

0 - No
1 - Yes

How old were you when this first occurred?

Did this occur during the past year? [Answer separately for past month and other 11 months.]
0 - No
1 - Yes

How about during the past month?
0 - No
1 - Yes

	EVER	AGE FIRST	PAST YEAR 11 MONTHS	PAST YEAR PAST MONTH
33 - **Stole** Stole substances, stole money to buy substances, and/or used money obtained through the sale of stolen articles to buy substances	☐	☐☐	☐	☐
34 - **Exchanged sex for drugs** Obtained substances in exchange for sex, and/or used money obtained from sexual activity to buy substances	☐	☐☐	☐	☐
35 - **Dealt drugs** Dealt drugs for drugs, skimmed off dealt drugs for personal use, and/or used money from dealing to buy drugs	☐	☐☐	☐	☐

FOR ITEMS 36 - 37 COMPLETE THE FOLLOWING:

Have you ever _____?
0 - No
1 - Yes

How many times have you _____?

How old were you when this first occurred?

Did this occur in the past year? [Answer separately for past month and other 11 months.]
0 - No
1 - Yes

How about during the past month?
0 - No
1 - Yes

	EVER	TOTAL	AGE FIRST	PAST YEAR 11 MONTHS	PAST YEAR PAST MONTH
36 - Blacked out from alcohol	☐	☐☐	☐☐	☐	☐
37 - Overdosed on drugs	☐	☐☐	☐☐	☐	☐

FOR ITEMS 38 - 41 COMPLETE THE FOLLOWING:

Have you ever been treated for substance use in a(n) _____ setting?
0 - No
1 - Yes

How many times have you been treated for substance use in a(n) _____ setting? [A treatment episode is a block of treatment sessions with temporal breaks (e.g., 6 months) in between. Do not include each therapeutic contact.]

How old were you when this first occurred?

Did this occur during the past year? [Answer separately for past month and other 11 months.]
0 - No
1 - Yes

USE OF FREE TIME (Time not spent in school)

IS THE SUBJECT CURRENTLY ENROLLED IN SCHOOL AND CURRENTLY ATTENDING SCHOOL?

☐ No

☐ Yes - Complete Sections I and III

IS THE SUBJECT CURRENTLY NOT ENROLLED IN SCHOOL OR CURRENTLY NOT ATTENDING SCHOOL? (DO NOT INCLUDE SUMMER VACATION)

☐ No

☐ Yes - Complete Sections I, II and III

I. EMPLOYMENT

	EVER	AGE FIRST	PAST 11 MONTHS	PAST YEAR PAST MONTH
	☐	☐☐	☐	☐

1 - Employed
- 0 - No
- 1 - Yes, with on-site supervision
- 2 - Yes, without on-site supervision

☐

2 - Employment related to career goals, e.g., position: data entry - career goal: Computer Programmer
- 0 - No
- 1 - Yes

☐

3 - Typical work pattern:
- 1 - Summers only
- 2 - Weekends
- 3 - Weekdays
- 4 - Evenings
- 5 - Evenings & Weekends
- 6 - Evenings & Weekdays
- 7 - Weekends & Weekdays
- 8 - All
- 9 - Other _____

Typical number per week:

Days: ☐

Hours: ☐☐

4 - Total number of times fired ☐☐

5 - Valid driver's license ☐
0 - No
1 - Privilege to obtain license suspended
2 - Revoked license
3 - Yes - valid license

FOR ITEM 6 COMPLETE THE FOLLOWING:

In the past year, have you had significant periods in which _____?
[Answer separately for past month and other 11 months.]
0 - No
1 - Yes

How about during the past month?
0 - No
1 - Yes

	PAST 11 MONTHS	PAST YEAR PAST MONTH
6 - Job Interference Your job interfered with school, family, peer, or leisure activities, e.g., there wasn't enough time to do your homework	☐	☐
7 - Major source of support 1 - Parent(s)/Guardian(s) 2 - Employment 3 - Illegal means 4 - Welfare 5 - None 6 - Other _____	☐	☐

8 - Sources of income used solely for recreational purposes in the past year:
0 - No
1 - Yes

A. Parent(s)/Guardian(s) ☐

B. Employment ☐

C. Illegal means ☐

D. Welfare ☐

E. Other _____ ☐

Record major source (choose one) ☐

II. CURRENTLY NOT ENROLLED IN SCHOOL OR NOT ATTENDING SCHOOL (EXCLUDING SUMMER VACATION)

FOR ITEMS 9 - 10 COMPLETE THE FOLLOWING:

Upon disenrollment from school, _____?
0 - No
1 - Yes

How about during the past year? [Answer separately for past month and other 11 months.]
0 - No
1 - Yes

How about during the past month?
0 - No
1 - Yes

	UPON D.E.	PAST YEAR 11 MONTHS	PAST MONTH
9 - Were you self supportive Required to pay all bills, e.g., medical, food, shelter. [If living with parent(s)/guardian(s), must pay a percentage of rent, utilities, etc., to qualify as self-supportive.] 0 - No 1 - Yes	☐	☐	☐
10 - Was your income sufficient to meet your needs 0 - No 1 - Yes	☐	☐	☐

COMPLETE ITEMS 11 - 12 ONLY IF CURRENTLY EMPLOYED AND NOT IN SCHOOL

Are there _____?
0 - No
1 - Yes

11 - Training programs which will result in a marketable skill and/or a promotion and/or a substantial raise ☐

12 - Opportunities for advancement within the company ☐

COMPLETE ITEMS 13 - 14 ONLY IF CURRENTLY UNEMPLOYED AND NOT IN SCHOOL

13 - Reason for not working ☐
1 - Medical circumstances
2 - Psychiatric circumstances
3 - Drug/alcohol circumstances
4 - Unable to find a job
5 - Not actively seeking employment
6 - Other_____

14 - Actively seeking employment, e.g., completing applications, answering advertisements
0 - No
1 - Yes

III. LEISURE ACTIVITIES

FOR ITEMS 15 - 17 COMPLETE THE FOLLOWING:

Have you ever participated in _____ on a consistent basis?
0 - No
1 - Yes

How old were you when you first began participating in _____?

When you first began participating in _____, was this done the majority of the time in conjunction with drug use?
0 - No
1 - Yes, with drug use
2 - Yes, without drug use

Did you participate in _____ in the past year, and if so, was this done the majority of the time in conjunction with drug use? [Answer separately for past month and other 11 months.]
0 - No
1 - Yes, with drug use
2 - Yes, without drug use?

How about during the past month, and if so, was this done the majority of the time in conjunction with drug use?
0 - No
1 - Yes, with drug use
2 - Yes, without drug use

	EVER	AGE FIRST	PAST 11 MONTHS	PAST YEAR PAST MONTH
15 - Organized activities, volunteer, community service or civic work	☐	☐☐ ☐	☐	☐
16 - An exercise program, e.g., aerobics, jogging. [Do not include gym class at school. This does not need to be a formal program to be scored yes.]	☐	☐☐ ☐	☐	☐
17 - Loitering, cruising, "hanging-out"	☐	☐☐ ☐	☐	☐

	PAST 11 MONTHS	PAST YEAR MONTH
18 - Most of free time is spent with	☐	☐
1 - Drug using peer(s)		
2 - Non-drug using peer(s)		
3 - Drug using girlfriend/boyfriend		
4 - Non-drug using girlfriend/boyfriend		
5 - Drug using family member(s)		
6 - Non-drug using family member(s)		
7 - Co-worker(s)		
8 - Alone		
9 - Other _____		
19 - Most of free time is spent	☐	☐
1 - Listening to music		
2 - Watching TV		
3 - Playing electronic games		
4 - Talking on the phone		
5 - Reading		
6 - "Hanging-out"		
7 - Partying - doing drugs		
8 - Playing sports		
9 - Working		
10 - Other _____		
20 - Are you satisfied with the way in which you use your free time?		☐
0 - No		
1 - Yes		
21 - Do you think that you have any problems with the way you use your free time?		☐
0 - No		
1 - Maybe		
2 - Definitely		
22 - In the past month, how often have you experienced issues with the way in which you used your free time that bothered you?		☐
0 - Never		
1 - Occasionally		
2 - Almost every day		
3 - Daily		

FOR ITEMS 23 - 24 PLEASE ASK SUBJECT TO USE THE SUBJECT'S RATING SCALE

23 - Have you been troubled or bothered by any of these issues in the past month?	☐

24 - Is counseling in this area important to you?

CONFIDENCE RATINGS

Is the above information significantly distorted by:

25 - Subject's misrepresentation?
0 - No
1 - Yes

26 - Subject's inability to understand?
0 - No
1 - Yes

COMMENTS

PEER RELATIONSHIPS

FOR ITEMS 1 - 9 COMPLETE THE FOLLOWING:

Have you ever had significant periods in which you ___?
0 - No
1 - Yes

How old were you when this first occurred?

Did this occur during the past year? [Answer separately for past month and other 11 months.]
0 - No
1 - Yes

How about during the past month?
0 - No
1 - Yes

	EVER	AGE FIRST	PAST 11 MONTHS	PAST YEAR PAST MONTH
1 - Had difficulty making or keeping friends	☐	☐☐	☐	☐
2 - Had no friends	☐	☐☐	☐	☐
3 - Preferred to be alone rather than with others	☐	☐☐	☐	☐
4 - Felt that your friends were not loyal, not trustworthy, talked behind your back, were two-faced	☐	☐☐	☐	☐
5 - Found it difficult or would not communicate about sensitive issues, would not "open-up" to your friends	☐	☐☐	☐	☐
6 - Were dissatisfied with the quality of the relationships with your friends	☐	☐☐	☐	☐
7 - Were consistently teased or bullied by your peers	☐	☐☐	☐	☐
8 - Bullied your peers or initiated physical fights	☐	☐☐	☐	☐
9 - Had difficulty establishing "romantic" relationships or were upset by the lack of such relationships	☐	☐☐	☐	☐

10 - Name of peer group (e.g., jocks) to which most of your friends belong

PAST 11 MONTHS

11 - In the past 11 months, was there anyone you could really trust, depend on, or count on to support you, and if so, who?

0 - No
1 - Drug using peer
2 - Non-drug using peer
3 - Drug using girlfriend/boyfriend
4 - Non-drug using girlfriend/boyfriend
5 - Drug using family member
6 - Non-drug using family member
7 - Adult (not family)
8 - Professional
9 - Other _____

PAST MONTH

11a- What about in the past month, and if so, who?

0 - No
1 - Drug using peer
2 - Non-drug using peer
3 - Drug using girlfriend/boyfriend
4 - Non-drug using girlfriend/boyfriend
5 - Drug using family member
6 - Non-drug using family member
7 - Adult (not family)
8 - Professional
9 - Other _____

FOR ITEMS 12 - 16 (EXCLUDING ITEM 15) COMPLETE THE FOLLOWING:

Have you ever hung around people that ___?

0 - No
1 - Yes

Did this occur during the past year? [Answer separately for past month and other 11 months.]

0 - No
1 - Yes, some of friends
2 - Yes, majority of friends

Did this occur during the past month?
0 - No
1 - Yes, some of friends
2 - Yes, majority of friends

	EVER	PAST YEAR 11 MONTHS	PAST YEAR PAST MONTH
12 - Were significantly older/younger than you	☐	☐	☐
13 - Used drugs or became intoxicated on alcohol regularly/received treatment for substance use	☐	☐	☐
14 - Committed illegal acts or got into trouble with the police/juvenile system Illegal act(s) _____	☐	☐	☐

15 - Age when one of the events mentioned in questions 12-14 first occurred — AGE FIRST ☐☐

	PAST YEAR 11 MONTHS	PAST YEAR PAST MONTH
16 - Supported not using drugs or alcohol 0 - No 1 - Yes, some friends 2 - Yes, majority of friends	☐	☐

FOR ITEMS 17 - 21 (EXCLUDING ITEM 18) COMPLETE THE FOLLOWING:

Have you ever ___?
0 - No
1 - Yes

How old were you when this first occurred?

Did this occur during the past year? [Answer separately for past month and other 11 months.]
0 - No
1 - Yes

How about during the past month?
0 - No
1 - Yes

	EVER	AGE FIRST	PAST 11 MONTHS	PAST YEAR PAST MONTH
17 - Voluntarily engaged in sexual activity	☐	☐☐	☐	☐
18 - Number of different sexual partners	☐☐		☐☐	☐☐
19 - Engaged in sexual activity against your will (non-relative)	☐	☐☐	☐	☐
20 - Forced someone to engage in sexual activity against their will	☐	☐☐	☐	☐
21 - Been tested for a sexually transmitted disease (STD)	☐	☐☐	☐	☐
0 - No 1 - Yes, negative result 2 - Yes, positive result List STD_____ 3 - Yes, do not know result		☐		
22 - Been tested for AIDS	☐	☐☐	☐	☐
0 - No 1 - Yes, negative result 2 - Yes, positive result 3 - Yes, do not know result		☐		
23 - Had sex with someone who has or might have AIDS (e.g., prostitute, IV drug user, homosexual, bisexual)	☐	☐☐	☐	☐
0 - No 1 - Yes 2 - Don't know		☐		
24 - Been pregnant or impregnated someone	☐	☐☐	☐	☐
If yes, what happened: 0 - No 1- Abortion 2 - Miscarriage 3 - Adoption 4 - Kept the baby 5 - Baby taken away 6 - Still pregnant 7 - Other _____		☐		
Total Number of Pregnancies*				☐☐*

FOR ITEMS 25 - 28 COMPLETE THE FOLLOWING:

Have you (or your partner) ever ____?
0 - No
1 - Yes

How old were you when you first ____?

How often have you (or your partner) _____ in the past year?
0 - Never
1 - Sometimes
2 - Almost always
3 - Always

How often have you (or your partner) _____ in the past month?
0 - Never
1 - Sometimes
2 - Almost always
3 - Always

	EVER	AGE FIRST	PAST 11 MONTHS	PAST YEAR PAST MONTH
25 - Used a contraceptive (excluding condoms)	☐	☐☐	☐	☐
List reasons for use	☐			
List contraceptive	☐			
26 - Used a condom	☐	☐☐	☐	☐
List reasons for use	☐			
				☐

27 - Do you think that you have problems with your relationships with peers?
0 - No
1 - Maybe
2 - Definitely

☐☐

28 - In the past month, how often have you experienced issues with your relationships with peers which bothered you?
0 - Never
1 - Occasionally
2 - Almost every day
3 - Daily

FOR ITEMS 29 - 30 PLEASE ASK SUBJECT TO USE THE SUBJECT'S RATING SCALE

29 - Have you been troubled or bothered in the past month by any of these issues? ☐

30 - Is treatment or counseling important to you in these areas? ☐

CONFIDENCE RATINGS

Is the above information significantly distorted by:

31 - Subject's misrepresentation? ☐
0 - No
1 - Yes

32 - Subject's inability to understand? ☐
0 - No
1 - Yes

COMMENTS

FAMILY RELATIONSHIPS

1 - Current living situation

- 1 - Both biological parents
- 2 - Biological mother
- 3 - Biological father
- 4 - Mother and male guardian
- 5 - Father and female guardian
- 6 - Mother and live-in boyfriend
- 7 - Father and live-in girlfriend
- 8 - Adoptive parent(s)
- 9 - Foster parent(s)
- 10 - Other relatives _____
- 11 - Friends
- 12 - Sexual partner/spouse
- 13 - Alone
- 14 - Other _____

2 - If lived in this situation less than 1 month, record "usual" arrangements

3 - Reasons not being raised/were not raised by biological parent(s)

	FATHER	MOTHER
	☐	☐

- 1 - Separation
- 2 - Divorce
- 3 - Adoption
- 4 - Foster care
- 5 - Death
- 6 - Parents never married
- 7 - Other _____

4 - Age at initial separation from biological parent(s)

FATHER	MOTHER
☐☐	☐☐

5 - If separated from biological parent(s), record type of contact:

	FATHER		MOTHER	
	PAST 11 MONTHS	YEAR PAST MONTH	PAST 11 MONTHS	YEAR PAST MONTH
Between you and your biological parent(s)				
0 - No contact				
1 - Indifferent contact	☐	☐	☐	☐
2 - Negative contact				
3 - Positive contact				
Between biological parents				
0 - No contact				
1 - Indifferent contact	☐	☐		
2 - Negative contact				
3 - Positive contact				

[ANSWER ITEMS 6 - 8 IF SUBJECT IS ADOPTED, AND SUBJECT'S ADOPTIVE PARENTS ARE NOT TOGETHER]

FATHER MOTHER

6 - Reasons not being raised/were not raised by adoptive parent(s)
1 - Separation
2 - Divorce
3 - Foster care
4 - Death
5 - Other ______________________________

FATHER MOTHER

7 - Age at initial separation from adoptive parent(s)

8 - If separated from adoptive parent(s), record type of contact:

	FATHER PAST 11 MONTHS	FATHER YEAR PAST MONTH	MOTHER PAST 11 MONTHS	MOTHER YEAR PAST MONTH
Between you and your adoptive parent(s) 0 - No contact 1 - Indifferent contact 2 - Negative contact 3 - Positive contact	☐	☐	☐	☐
Between adoptive parents 0 - No contact 1 - Indifferent contact 2 - Negative contact 3 - Positive contact	☐	☐		

9 - Number of biological/adoptive sisters ☐ Number of stepsisters ☐

Number of biological/adoptive brothers ☐ Number of stepbrothers ☐

10 - Father's/male guardian's educational level

Father's/male guardian's occupation

Mother's/female guardian's educational level

Mother's/female guardian's occupation

FOR ITEMS 11 - 17 COMPLETE THE FOLLOWING:

Have you or any other family member(s) ever _____?

How old were you when this first occurred?

Did it occur during the past year, and if so, by whom? [Answer separately for past month and other 11 months.]

0 - No
1 - Patient
2 - Parent(s)/Guardian(s)
3 - Sibling(s)
4 - Patient and Parent(s)/Guardian(s)
5 - Patient and Sibling(s)
6 - Parent(s)/Sibling(s)
7 - Parent's Girlfriend/Boyfriend
8 - Patient and parent's girlfriend/boyfriend
9 - Parent's girlfriend/boyfriend and another family member excluding patient
10 - All family members
11 - All family members including parent's girlfriend/boyfriend
12 - Other _____

How about the past month, and if so, by whom?

0 - No
1 - Patient
2 - Parent(s)/Guardian(s)
3 - Sibling(s)
4 - Patient and Parent(s)/Guardian(s)
5 - Patient and Sibling(s)
6 - Parent(s)/Sibling(s)
7 - Parent's Girlfriend/Boyfriend
8 - Patient and parent's girlfriend/boyfriend
9 - Parent's girlfriend/boyfriend and another family member excluding patient
10 - All family members
11 - All family members including parent's girlfriend/boyfriend
12 - Other _____

	EVER	AGE FIRST	PAST YEAR 11 MONTHS	PAST YEAR PAST MONTH
11 - Gotten so angry that furniture was destroyed, objects were thrown, doors or walls were punched	☐	☐☐	☐	☐
		☐		
12 - Hit another family member so hard that s/he had bruises/broken bones or had to be taken to the hospital, i.e., were physically abused	☐	☐☐	☐	☐
		☐		

	EVER	AGE FIRST	PAST 11 MONTHS	PAST YEAR PAST MONTH
13 - Engaged in sexual activity against your/their will, i.e., were sexually abused	☐	☐☐	☐	☐
14 - Could not get along for an extended period of time, e.g., verbal fighting, name calling	☐	☐☐	☐	☐
15 - Found it difficult or would not communicate about sensitive issues	☐	☐☐ ☐	☐	☐
16 - Been contacted by the police or outside agency (e.g., child welfare department), about any family problems or disputes	☐	☐☐ ☐	☐	☐
17 - Run away from home or been placed in an alternative living arrangement	☐	☐☐ ☐	☐	☐

FOR ITEMS 18 - 27 COMPLETE THE FOLLOWING:

Has there ever been a significant period of time when _____?
0 - No
1 - Yes

How old were you when this first occurred?

Did this occur during the past year? [Answer separately for past month and other 11 months.]
0 - No
1 - Yes

How about the past month?
0 - No
1 - Yes

	EVER	AGE FIRST	PAST 11 MONTHS	PAST YEAR PAST MONTH
18 - You felt that you could not confide in your parent(s), that what you said was unimportant to your parent(s), that your opinion did not matter, or that you were never taken seriously	☐	☐☐	☐	☐

	EVER	AGE FIRST	PAST 11 MONTHS	PAST YEAR MONTH
19 - You felt that your parent(s) were unavailable to you, that they were not there when you needed them	☐	☐☐	☐	☐
20 - You felt that your parent(s)' expectations of you were unrealistic	☐	☐☐	☐	☐
21 - You contributed to or took responsibility for your family, e.g., provided income, consistently supervised/raised a sibling	☐	☐☐	☐	☐
22 - Lack of family rules, structure or supervision. There were no rules (e.g., you were given as much freedom as you wanted, you were allowed to go out as often as you wanted), your parent(s) were unaware of your activities and/or whereabouts, your parent(s) were not home most of the time	☐	☐☐	☐	☐
23 - Parent(s) too overprotective Your parent(s) tried to control everything you did, invaded your privacy by going through your things, listened in on phone conversations, tended to baby you	☐	☐☐	☐	☐
24 - Your parent(s) covered for you (e.g., made excuses to school so that you would not get into trouble), did not tell your other parent things that happened	☐	☐☐	☐	☐
25 - Rules were not consistently enforced, there was generally no follow through or consequences if you broke the rules, you received "mixed messages"	☐	☐☐	☐	☐
26 - Your parents disagreed on how to handle you, disagreed on limits, disagreed on consequences	☐	☐☐	☐	☐
27 - Your family participated in counseling/ family therapy	☐	☐☐	☐	☐
FOR THOSE WHO REPORT SUBSTANCE USE 28 - Your parent(s) were aware of your substance use but did not address it	☐	☐☐	☐	☐

29 - PARENTING STYLE
Present scenarios (Appendix H) and have the adolescent choose the description which best describes his/her parent(s)

FOR ITEMS 30 - 32 COMPLETE THE FOLLOWING:

Has anyone in your family ever _____?

How old were you when this first occurred?

Did it occur during the past year, and if so, by whom? [Answer separately for past month and other 11 months.]

0 - No
1 - 1st degree relative
2 - 2nd degree relative
3 - Adoptive parents/guardian/live-in girlfriend/boyfriend of parent
4 - 1st or 2nd degree relative and adoptive/guardian/live-in girlfriend/boyfriend of parent
5 - Other _____

How about the past month, and if so, by whom?

0 - No
1 - 1st degree relative
2 - 2nd degree relative
3 - Adoptive parents/guardian/live-in girlfriend/boyfriend of parent
4 - 1st or 2nd degree relative and adoptive/guardian/live-in girlfriend/boyfriend of parent
5 - Other _____

	EVER	AGE FIRST	PAST 11 MONTHS	PAST YEAR MONTH
30 - Received treatment for drugs or alcohol, became intoxicated or used drugs regularly Who? _____	☐	☐☐ ☐	☐	☐
31 - Received treatment for any emotional problems such as depression, anxiety or attempted/committed suicide Who? _____	☐	☐☐ ☐	☐	☐
32 - Committed, been charged, or convicted of illegal acts Who? _____	☐	☐☐ ☐	☐	☐

33 - Do you feel that you have any family problems?
0 - No
1 - Maybe
2 - Definitely

34 - In the past month, how often have you experienced issues with your family which bothered you?
0 - Never
1 - Occasionally
2 - Almost every day
3 - Daily

FOR ITEMS 35 - 36 PLEASE ASK SUBJECT TO USE THE SUBJECT'S RATING SCALE

35 - Have you been troubled or bothered by these issues in the past month?

36 - Is treatment in this area important to you?

CONFIDENCE RATINGS

Is the above information significantly distorted by:

37 - Subject's misrepresentation?
0 - No
1 - Yes

38 - Subject's inability to understand?
0 - No
1 - Yes

COMMENTS

LEGAL STATUS

FOR ITEMS 1 - 8 COMPLETE THE FOLLOWING:

Have you ever _____?
0 - No
1 - Yes

How old were you when this first occurred?

Did this occur during the past year? [Answer separately for past month and other 11 months.]
0 - No
1 - Yes

How about during the past month?
0 - No
1 - Yes

	EVER	AGE FIRST	PAST 11 MONTHS	PAST YEAR PAST MONTH
1 - Committed a crime	☐	☐☐	☐	☐
*Code first offense (use Appendix I) (Record offenses in Comments section 8-3)		☐☐*		
2 - Been picked up by the police	☐	☐☐	☐	☐
3 - Been seen by a probation officer	☐	☐☐	☐	☐
4 - Been charged with a crime (List charges in Comments section 8-3)	☐	☐☐	☐	☐
5 - Appeared before a judge (List reasons in Comments section 8-3)	☐	☐☐	☐	☐
6 - Been convicted of a crime (List convictions in Comments section 8-3)	☐	☐☐	☐	☐
* Total number of convictions	☐☐*			
7 - Been on probation	☐	☐☐	☐	☐
8 - Spent time in a juvenile detention facility or jail	☐	☐☐	☐	☐
9 - Are you currently awaiting charges, trial, or sentencing? (List reasons in Comments section 8-3)				☐

10 - Do you think that you have problems with the law?
0 - No
1 - Maybe
2 - Definitely

11 - In the past month, how often have you experienced issues with the law which bothered you?
0 - Never
1 - Occasionally
2 - Almost daily
3 - Daily

FOR ITEMS 12 - 13 PLEASE ASK SUBJECT TO USE THE SUBJECT RATING SCALE

12 - How troubled or bothered are you by these issues?

13 - How important to you now is legal service?

CONFIDENCE RATINGS

Is the above information significantly distorted by:

14 - Subject's misrepresentation?
0 - No
1 - Yes

15 - Subject's inability to understand?
0 - No
1 - Yes

COMMENTS

PSYCHIATRIC STATUS

FOR ITEMS 1 - 3 COMPLETE THE FOLLOWING:

Have you ever been treated for psychological or emotional problems in a(n) _____ setting? (For Item 3, has someone ever prescribed medication for you for a psychological or emotional problem?)

How many times have you been treated for psychological or emotional problems in a(n) setting? [A treatment episode is a block of treatment sessions with temporal breaks (e.g., 6 months) in between. Do not include each therapeutic contact.]

How old were you when this first occurred?

Did this occur during the past year? [Answer separately for past month and other 11 months.]
0 - No
1 - Yes

How about during the past month?
0 - No
1 - Yes

	EVER	TREATMENT EPISODES	AGE FIRST	PAST 11 MONTHS	YEAR PAST MONTH
1 - Outpatient	☐	☐☐	☐☐	☐	☐
2 - Inpatient	☐	☐☐	☐☐	☐	☐
3 - Prescribed medication for psychological or emotional problems	☐		☐☐	☐	☐

FOR ITEMS 4 - 21 COMPLETE THE FOLLOWING:

Have you ever had a significant period (which lasted two weeks or longer) during which you ____?
0 - No
1 - Yes

How old were you when this first occurred?

Did this occur during the past year? [Answer separately for past month and other 11 months.]

0 - No
1 - Yes, a direct result of substance use
2 - Yes, difficult to determine whether a direct result of substance use
3 - Yes, not a direct result of substance use

How about during the past month?

0 - No
1 - Yes, a direct result of substance use
2 - Yes, difficult to determine whether a direct result of substance use
3 - Yes, not a direct result of substance use

	EVER	AGE FIRST	PAST 11 MONTHS	PAST YEAR MONTH
4 - Had consistent thoughts of failure, lacked self-confidence, were dissatisfied with yourself, felt you could not do anything right, felt inferior to others	☐	☐☐ ☐	☐	☐
5 - Were extremely intimidated, shy, felt withdrawn or self conscious, were afraid of new situations	☐	☐☐ ☐	☐	☐
6 - Were confused and/or distressed about long term goals, a career choice or plan, a religious choice or your sexual orientation	☐	☐☐ ☐	☐	☐
7 - Were restless, fidgety, had excessive activity, could not sit still, were extremely distractible	☐	☐☐ ☐	☐	☐
8 - Were extremely anxious, keyed-up or on edge, tense, unable to relax, worried excessively, felt panicky, had sweaty or cold, clammy hands, had your heart pound or race, felt sick to your stomach when you were not physically ill	☐	☐☐ ☐	☐	☐

	EVER	AGE FIRST	PAST 11 MONTHS	PAST YEAR MONTH
9 - Acted too quickly without thinking things through, were impulsive on a regular basis, did dangerous things for the thrill of it, were often said to be hot headed	☐	☐☐ ☐	☐	☐
10 - Intentionally violated rules, refused requests, were rebellious, did things to purposely annoy other people, were spiteful	☐	☐☐ ☐	☐	☐
11 - Consistently lost your temper, argued with adults, were angry and resentful	☐	☐☐ ☐	☐	☐
12 - Were extremely hostile or physically violent which was difficult if not impossible to control, had sudden and excessive outbursts	☐	☐☐ ☐	☐	☐
13 - Were constantly preoccupied with food, weight and shape.	☐	☐☐ ☐	☐	☐
14 - Had thoughts you could not get rid of, had to do things over and over again	☐	☐☐ ☐	☐	☐
15 - Felt sad, hopeless, always "bummed out", cried excessively	☐	☐☐ ☐	☐	☐
16 - Lost interest in things that were once important, were extremely tired, had little energy	☐	☐☐ ☐	☐	☐
17 - Experienced serious thoughts of suicide	☐	☐☐ ☐	☐	☐
18 - Attempted suicide	☐	☐☐ ☐	☐	☐
19 - Did things to physically hurt yourself intentionally, i.e., engaged in self-mutilating behavior	☐	☐☐ ☐	☐	☐

	EVER	AGE FIRST	PAST 11 MONTHS	PAST YEAR PAST MONTH
20 - Had a tremendous amount of energy or engaged in significantly more activity than is usual for you, felt euphoric, were extremely talkative	☐	☐☐	☐	☐
21 - Heard voices other people did not hear, saw or smelled things other people did not see or smell, had delusions or, hallucinations, felt paranoid or extremely suspicious	☐	☐☐	☐	☐
22 - Do you think you have any psychological or emotional problems? 0 - No 1 - Maybe 2 - Definitely		☐		☐
23 - In the past month, how often have you experienced any of the above? 0 - Never 1 - Occasionally 2 - Almost every day 3 - Daily				☐☐

FOR ITEMS 24 - 25 PLEASE ASK THE SUBJECT TO USE THE SUBJECT'S RATING SCALE

24 - Have you been troubled or bothered by these issues in the past month? ☐

25 - Is treatment or counseling important to you for these issues? ☐

THE FOLLOWING ITEMS ARE TO BE COMPLETED BY THE INTERVIEWER

At the time of the interview, was the patient ___?
0 - No
1 - Yes

26 - Obviously depressed/withdrawn ☐

27 - Obviously hostile/angry ☐

28 - Having trouble with reality testing, distorted thinking, paranoid thinking ☐

29 - Having trouble comprehending, concentrating, remembering ☐

30 - Having suicidal thoughts ☐

CONFIDENCE RATINGS

Is the above representation significantly distorted by:

31 - Subject's misrepresentation? ☐
0 - No
1 - Yes

32 - Subject's inability to understand? ☐
0 - No
1 - Yes

COMMENTS

PROTOTYPE SCREENING/TRIAGE FORM FOR USE IN JUVENILE DETENTION CENTERS

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August 1990

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INTRODUCTION

The attached screening/triage form has been developed from our experience in research and service projects at the Hillsborough Regional Juvenile Detention Center in Tampa since 1984; and it incorporates several items from a Florida Statewide assessment tool currently in use at detention centers in the state. Many items or question sets from this protocol have been found to be psychometrically sound in a number of research studies we have completed. Appendix A lists a number of articles and a book chapter reporting our findings.

The instrument obtains information on experiences in the lives of detained juveniles we have found to be important in understanding their current situation and that relate to their patterns of drug use and delinquency/crime over time. The protocol reflects our experience that youths being assessed need to be seen in holistic terms.

However, it is important that users of this instrument consider a number of issues. First, the instrument is designed to be a screening/triage tool to identify youths who appear to be in need of further, detailed evaluation for an alcohol/other drug use or mental health problem. It is not intended to serve as a substitute for this detailed assessment process. Second, the issue of confidentiality of the information collected by use of this form needs to be considered in regard to its influence on the truthfulness of the youths' reports of their alcohol/other drug use or such of sensitive experiences as physical abuse or sexual victimization. Third, and related to the second consideration, it is important that objective data be obtained on the youths' alcohol/other drug use--such as that provided by urine testing or hair analysis.

We have found that thoughtful use of the items in this instrument has proven valuable in understanding the needs of detained juveniles, and in addressing their problems. We hope this protocol will prove useful to others.

PROTOTYPE SCREENING/TRIAGE FORM FOR USE IN DETENTION

Target Population

Juvenile detainees

Purpose

Assess juvenile risk and needs within detention setting.

Information Gathered

This subjective/objective instrument processes demographic information, home/living situations, alcohol and drug use, sexual abuse history, family history, psychological and medical history and criminal justice history. The information gathered establishes juveniles risk in each information area and service need in each area and is based on clinical judgment.

Application/Time Requirements

A 45-minute face-to-face interview with the juvenile is required. Scoring can take up to 20 minutes depending upon problem areas identified.

Administration/Training Requirements

Skilled interviewers whose training includes role playing, mock interviews, and rapport building techniques.

Validity/Reliability

This instrument has yet to be fully validated. Many items and sections are taken from instruments applied to the same populations since 1985 which have proven validity. Five years of research and experience support the instrument.

Utility and Restrictions

The Prototype Screening Triage Form covers a wide range of juvenile problem areas which assists in the identification of high-risk youth and their potential service needs. Rapport building with clients and use of the instrument in non-adversarial circumstances improve validity. Limited use to date.

Comments

Drug testing in combination with self-report contributes to reliability.

ADMISSION & DEMOGRAPHIC INFORMATION

Date Admitted to Detention Center:_____ Time Admitted:_____

Date Judge Ordered to Secure:_____

Date of Screen:_____ Time of Screen:_____

Completing Screener:_____

1. IDENTIFYING DATA: (TO BE COMPLETED BY SCREENER):

Name:_____ Sex:____ Date of Birth:_____

Age:_____

Ethnicity: 1. American Indian
2. Asian American
3. Black
4. Hispanic (specify_____)
5. Anglo
6. Other (specify_____)

Pending Charge: Delinquency Charge_____

Dependency Case_____

Other (specifics)_____

2. REASON FOR PLACEMENT IN DETENTION: (Please get specifics):

_____

_____

_____

_____

_____

EDUCATION AND EMPLOYMENT INFORMATION

Education

1. Name of school in which enrolled or last attended: _____

2. Highest grade completed: _____ GED: Yes___ No___

3. Date last attended: _____

4a. Suspended: _____ times for _____
b. Expelled: _____ times for _____

5. Was youth ever in a special education program (e.g., educationally handicapped, learning disabilities)

Yes ____ No ____

If yes, get details (grades/years, reasons)

_____

_____

_____

Employment

	Type of Job	Dates
1. Current Employment:		
2. Previous Employment:		
3. Vocational Training skills:		

HOME/LIVING SITUATION

1. What are the names of the people whose household you live in? (Probe for primary caregivers):

   _____

2. How are you related to these people?

   ___ Biological Parents
   ___ Mother and Stepfather
   ___ Father and Stepmother
   ___ Mother Only
   ___ Other Arrangement (please specify)
   ___ Father Only
   ___ Aunt/Uncle
   ___ Grandparents
   ___ Brother/Sister

   _____

3. What is your home address:_____

4. Home phone number?_____

5. How long have you been living in this present household?

   _____years _____months

6. Whom do you feel closest to?_____

7. Who is the head of the household?_____

8. What is the occupation of head of the household in which you live?_____

   a. Is he/she currently employed? (get specifics)

   _____

9. How many families (or places) have you lived with(in) during the past year?

   _____

10. How many times have you run away from home?_____

    What was the longest period?_____

    Most recent date?_____

11. How many times have you been put or kicked out of your home?

    _____

    Most recent date?_____

    What was the youngest age you were put/kicked out of your home?
    _____ years

    Most recent date? _____

OTHER PERSONAL INFORMATION

1. Does your family attend church/synagogue?
   Yes ___ No ___

   If "yes," how often?_____

   What religious denomination?_____

2. What religious denomination do you identify with?
   _____

   (Probe for practice of Santa Ria, Palomey Omsi, Voodoo or Satanic rituals).

3. Are you a member of any gang? Yes ___ No ___
   If "yes," probe for specifics (e.g., gang name, etc.)
   _____

   _____

ALCOHOL/OTHER DRUG USE

Type of Drug	Ever Used Yes	Ever Used No	First Used	Frequency of use in the Last 12 Month(s)	Most Recent Use?(b)	Has Your Use Caused You Any Problem in the Past Year? (i.e, with school, friends, health, police, parents) Yes	Has Your Use Caused You Any Problem in the Past Year? (i.e, with school, friends, health, police, parents) No
1. Tobacco/Cigarettes							
2. Alcohol (beer, wine, wine coolers, liquors)							
3. Marjuana/hashish (grass, pot, smoke, cheeba, joint)							
4. Inhalants (sniff gasoline, paint, aerosol sprays, shoe shine/glue/toluene, paint thinner/solvents, white out liquid, other inhalents)							
5. Hallucinogens (LSD, PCP, Ecstasy, Peyote, some types of mushrooms, other hallucinogens)							
6. Cocaine (powder-snow, blow)							
7. Crack Cocaine (rock)							
8. Heroin/Other Opiates							
9. Other Drugs:							
MPTP							
China White							
Crystal Ice (methamphetamine)							
Other (specify)							
10. Steroids							
11. Non-Medical use of (c):							
Sedatives/Barbiturates (downers) e.g., Seconal							
Stimulants/Amphetamines/Diet Pills (speed, uppers) e.g., Dexadrine							
Tranquilizers e.g., Valium, Librium							
Pain Killing Pills e.g., Darvon							

a Frequency of use in the last 12 months?

99 Never used
00 Did not use in the past 12 months
01 1 or 2 days in the past 12 months
02 3 to 5 days in the past 12 months
03 Every other months or so, 6 to 11 days a year
04 1 to 2 times a month, 12 to 24 days a year
05 Several times a month, about 25 to 51 days a year
06 1 or 2 days a week
07 Almost daily, 3 to 6 days a week
08 Daily
09 Several times a day

b Most Recent Use?

01 more than 1 year ago
02 in the past year
03 6 months ago
04 3 months ago
05 a month ago
06 a week ago
07 yesterday/today

c Non-Medical use refers to:

1) to see what it was like and how it would work;
2) to enjoy the feeling it gave you;
3) for some other non-medical reason, and not because you needed it.

12. Have you ever received any treatment for an alcohol or other drug abuse problems?

Yes___ No___

If "yes;" Program Name:_____

Type:_____

Which Drug Problem:_____

Dates:_____

Outcome:_____

13. Did you ever take any drug with a needle? Yes___ No___

If "yes," which drug?_____

SEXUAL ABUSE HISTORY

More people have had sexual experiences while growing up. These experiences are with friends, playmates, relatives and family members. Some are with adults and others are with youths and some are painful and upsetting and others are not. I would first like you to tell me about your sexual experiences, if any, <u>with an adult</u> (someone 18 years of age or older) including strangers, state or government employee, friends or family memebers like cousins, aunts, uncles, brothers, sisters, mother or father. By "sexual experience" I mean a broad range of things, anything from playing "doctor" to sexual intercourse - in fact, anything that might have seemed "sexual" to you, such as touching sex organs, showing sex organs, intercourse, etc.

1. Have you ever had a sexual experience <u>with an adult</u>? such as touching sex organs, showing sex organs, intercourse, etc.

   Yes___ No___ (If "No," Go to Question 2:)

   a. How many of these experiences have you had with adults? _____

   (IF YOUTH HAS HAD MORE THAN ONE SEXUAL EXPERIENCE WITH AN ADULT, SAY: I would like for you to think back to the <u>first time</u> you had a sexual experience with an adult AND ASK QUESTIONS 1b to 1j BELOW)

   b. How old were you at the time?_____
   c. About how old was the adult?_____
   d. Was the other person male____ or female____?
   e. What was your relationship to the other person? (e.g., stranger, parent, stepparent, grandparent)
      _____
   f. Did he/she threaten or force you? Yes____ No____
   g. What was your reaction to this first experience?

	Yes	No
Fear for your safety	___	___
Shock	___	___
Surprise	___	___
Pleasure	___	___
Curiosity	___	___
Other(Specify)_____	___	___

      _____

   h. Was the adult with whom you had this first sexual experience under the influence of alcohol or other drug at the time?

      Yes____ No____

2. Now, I would like to ask you about any sexual experience you have had with any person, regardless of his/her age.

a. Have you ever had a sexual experience with anyone (IF CHILD CLAIMED EARLIER TO HAVE HAD A SEXUAL EXPERIENCE WITH AN ADULT, SAY "ANYONE OTHER THAN THE OCCASION YOU JUST REPORTED"?) such as touching sex organs, showing sex organs, intercourse, etc.

Yes___ No___ If "NO", GO TO THE NEXT SECTION

If "YES", ASK:

b. Did any of these experience involve your:

	Yes	No
Mother or Father	___	___
Stepmother of Stepfather	___	___
Grandmother of Grandfather	___	___

c. Did you ever have any of these sexual experience because you were threatened or forced?

Yes___ No___

If "Yes," ASK: How many times were you threatened or forced?

_____

d. ASK OF ALL YOUTHS: Did you have any of the following reactions to any of these sexual experience:

	Yes	No
Fear for your safety	___	___
Shock	___	___
Surprise	___	___
Pleasure	___	___
Curiosity	___	___
Other(specify)_____		

e. Did you have any of these sexual experiences when you were under age 13 years of age? yes ____ no ____

If "YES," ask: Did any of these sexual experiences involve a person 18 years of age or older? yes ____ no ____

f. Were any of the persons with whom you had a sexual experience under the influence of alcohol or other drug at the time?

Yes___ No___

PHYSICAL ABUSE HISTORY

1. Most people have had conflicts with others while growing up which can sometimes lead to physical blows such as being hit really hard, being kicked, punched, stabbed or in some other way being really hurt. Please tell me about your experiences like these, if any, with an adult (someone 18 years of age or older), including strangers, state or government employees, friends, or family members--like cousins, aunts, uncles, brother, sisters, mother or father.
Please do not give me any names. Have you ever:
(INTERVIEWER: PLEASE SCREEN OUT RECIPROCAL INJURIES SUCH AS OCCURRING IN INDIVIDUAL OR GANG FIGHTS)

	Yes	No	How many times were you hurt in this way?	About how old were you when this first happened to you?
Been beaten or really hurt by being hit (but not with anything)?	___	___	_____	_____
Been beaten or hit with a whip, strap or belt?	___	___	_____	_____
Been beaten or hit with something "hard" (like a club or stick)?	___	___	_____	_____
Been shot with a gun, injured with a knife, or had some other "weapon" used against you?	___	___	_____	_____
Been hurt badly enough by an adult to require (need) a doctor or bandages or other medical treatment?	___	___	_____	_____
Spent time in a hospital because you were physically injured by an adult?	___	___	_____	_____

2. Was any adult who caused you any physical harm you just mentioned under the influence of alcohol or other drugs at the time?

Yes___ No___ N/A___

3. Now, I would like to know if you have ever received any physical blows such as being hit <u>really</u> hard, being kicked, punched, stabbed or in some other way being really hurt by a person 17 years of age or younger, including strangers, friends, or family members -- like cousins, aunts, uncles, brothers, sisters, etc. Please do not give me any names. Have you ever:
(INTERVIEWER: PLEASE SCREEN OUT RECIPROCAL INJURIES SUCH AS OCCURING IN INDIVIDUAL OR GAND FIGHTS)

	Yes	No	How many times were you hurt in this way?	About how old were you when this first happened to you?
Been beaten or <u>really</u> by being hit (but not with anything)?	___	___	_____	_____
Been beaten or hit with a whip, strap or belt?	___	___	_____	_____
Been beaten or hit with something "hard" (like a club or stick)?	___	___	_____	_____
Been shot with a gun, injured with a knife, or had some other "weapon" used against you?	___	___	_____	_____
Been hurt badly enough by a person 17 years of age or younger to require (need) a doctor or bandages or other medical treatment?	___	___	_____	_____
Spent time in a hospital because you were physically injured by a person 17 years of age or younger?	___	___	_____	_____

4. Was any person 17 years of age or younger who caused you any physical harm you just mentioned under the influence of alcohol or other drugs at the time?

Yes_____ No_____ N/A_____

FAMILY HISTORY

Now, I would like to ask you some confidential questions about your family:

1. Has any member of your family or household family besides yourself ever had problems with alcohol abuse?

   Yes___ No___

   If "YES" ASK: Was treatment received? Yes___ No___

2. Do your parents allow you to drink at home? Yes___ No___

3. Has any member of your family or household family besides yourself ever had problems with other drug abuse?

   Yes___ No___

   If "YES" ASK: a. What drugs?_____.

   b. Did they receive drug treatment?
   Yes___ No___

4. Do your parents allow you to use drugs at home (e.g., marijuana)?

   Yes___ No___

5. Has any member of your family or household family besides yourself ever had emotional or mental problems?
   Yes___ No___

   If "YES", ASK: a. Did they receive treatment? Yes___ No___

   b. What type of treatment?
   hospital inpatient____ outpatient____
   both, hospital, inpatient and outpatient___
   (other specify_____).

6. Has any member of your family or household family besides yourself had involvement with the police or courts?

Yes___ No___

IF "YES", ASK: Have any of them been?

	Yes	No	Don't Know
Arrested	___	___	_____
Held in jail or detention	___	___	_____
Adjudicated delinquent or convicted of a crime	___	___	_____
Put on community control or probation	___	___	_____
Sent to a training school or prison	___	___	_____

7. Do you have any children of your own (i.e., given birth or fathered a child)? Yes___ No___.

PSYCHOLOGICAL/MEDICAL HISTORY

	Yes	No	If Yes, Get Age(s) and Details of Occurence
1. Have you seen a psychiatrist, psychologist, social worker, substance abuse or mental health counselor?	___	___	_____
2. Have you ever been hospitalized for: (a) a mental, emotional, behavior problem?	___	___	_____
(b) an alcohol/other drug problem?	___	___	_____
(c) Or other health problem?	___	___	_____
3. Have you ever tried to hurt yourself intentionally? (If "yes", probe for situation, motivation, whether youth was alone, severity, result?)	___	___	_____
(a) do you have thoughts of hurting yourself now?	___	___	_____
4. Have you ever taken medicine for your emotions or behavior problems? (If "yes", probe for which problems, duration, circumstances, helpfulness.)	___	___	_____
(a) are you taking medicine for that condition now? (If "yes" probe for which problems, duration, helpfulness)	___	___	_____
5. Are you under the care of a doctor for any physical or medical problems? (If "yes," probe for condition, duration, details regarding treatment, impact on daily life.)	___	___	_____
(a) When did you last see a doctor? _____ month/day/year			

6. Are you now taking medication? (If "yes," probe for medical condition and whether medication is prescribed.) ___ ___ _____

7. Have you ever seen anyone dying? (If "yes," probe for who was seen dying, age of youth at the time, whether the death was due to natural, violent or accidential causes.) ___ ___ _____

MENTAL HEALTH INFORMATION
(Appearance/Presentation Based primarily on observations)

	Yes	No	Comments
1) Does the client appear alert?	___	___	_____
2) Are there observable speech problem?	___	___	_____
3) Is there anything unusual about the client's appearance?	___	___	_____
4) Are there any observable problems with body movement (difficulties or unusual movements)?	___	___	_____
5) Is the client's mood and affect unusual?	___	___	_____
6) Is the client's activity level unusual?	___	___	_____
7) Does the client seem to have insight into his current problems?	___	___	_____
8) Does the client demonstrate capability of good judgement?	___	___	_____
9) Is client oriented to:			
person?	___	___	_____
place?	___	___	_____
time?	___	___	_____
10) Is there any evidence of halucinations?	___	___	_____
11) Is there any evidence of delusion?	___	___	_____
12) Does the client have unusual fears?	___	___	_____
13) Does the client have trouble thinking and expressing his thoughts?	___	___	_____

	Yes	No	Comments
14) Does the client exercise appropriate impulse control?	___	___	_____
15) Does the client appear depressed?	___	___	_____
16) Is there evidence of other bizarre behavior?	___	___	_____

CASE RECORD/FOLDER REVIEW

(This section is to be completed by the screener following an examination of the youth's official record.)

1. Documented evidence of having been a victim of physical abuse?

   Yes___ No___

   IF "YES," provide details:_____

   _____

   _____

2. Documented evidence of having been a victim of sexual abuse?

   Yes___ No___

   IF "YES," provide details:_____

   _____

   _____

3. Documented evidence of having been the perpetrator of physical or sexual abuse?

   Yes___ No___

   IF "YES," provide details:_____

   _____

   _____

4. Legal History

	Date	Disposition
a. Pending Offenses		
b. Prior Offenses	Date	Disposition

SUMMARY OF FINDINGS AND RECOMMENDATIONS

Client's Name:_____

RECOMMENDATIONS:

A. Client not in need of comprehensive assessment at this time. Explanation:

_____

_____

B. Client is recommended for direct referral for substance abuse treatment.

Yes___ No___

If yes, list provider name/address/phone and contact person.

_____

_____

C. Client is recommended for direct referral to a mental health agency.

Yes___ No___

If yes, list agency name/address/phone and contact person.

_____

_____

D. Client requires additional evaluation. Yes___ No___

If yes, list type of evaluation and to whom referral is made.

_____

_____

E. Family has agreed and is willing to follow through with recommendations.

Yes___ No___

COMMENTS AND SUMMARY OF RECOMMENDATIONS (Use additional space if needed):

SELECTED ARTICLES AND BOOK CHAPTER INVOLVING QUESTIONS/ITEM SETS ON THE PROTOTYPE SCREENING/TRIAGE FORM

R. Dembo, M. Dertke, L. LaVoie, S. Borders, M. Washburn, and J. Schmeidler

1987 Physical abuse, sexual victimization and illicit drug use: A structural analysis among high risk adolescents. Journal of Adolescence, 10:13-33.

R. Dembo

1988 Delinquency among Black, male youths. In J. T. Gibbs(ed.), Young, Black and Male: An Endangered Species. Boston: Auburn House.

R. Dembo, M. Dertke, S. Borders, M. Washburn, and J. Schmeider

1988 The relationship between physical and sexual abuse and tobacco, alcohol and illicit drug use among youths in a juvenile detention center. International Journal of the Addictions, 23: 351-378.

R. Dembo, L. Williams, E. Berry, A. Getreu, M. Washburn, E. D. Wish, J. Schmeidler, and M. Dertke

1988 The relationship between physical and sexual abuse and illicit drug use: A replication among a new sample of youths entering a juvenile detention center. International Journal of the Addictions, 23:1101-1123.

R. Dembo, C. D. Tjaden, M. Dertke, C. Garrett, and K. W. Wanberg

1989 The relationship between physical and sexual abuse and drug use in a sample of juvenile detainees in Florida and a sample of committed youthful offenders in Colorado. American Journal of Criminal Justice, 12:198-218.

R. Dembo, L. Williams, L. LaVoie, E. Berry, A. Getreu, E. D. Wish, J. Schmeidler, and M. Washburn

1989 Physical abuse, sexual victimization and illicit drug use: Replication of a structural analysis among a new sample of high risk youths. Violence and Victims, 4:121-138.

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